CONTRACT #3
RFS # 318.66-026
FA # 02-14632-00

Finance & Administration
Bureau of TennCare

VENDOR:
Volunteer State Health Plan, Inc. (TennCare Select)

STATE OF TENNESSEE
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

October 19, 2009

Mr. Jim White, Director
Fiscal Review Committee
8th Floor, Rachel Jackson Bldg.
Nashville, TN 37243

Attention: Ms. Leni Chick

RE: Bureau of TennCare Contract Amendments

Dear Mr. White:

The Department of Finance and Administration, Bureau of TennCare, is submitting for consideration by the Fiscal Review Committee, Amendment #21 to Volunteer State Health Plan, Inc. (TennCare Select), TennCare's provider of medical and behavioral services for children in state custody as well as other high risk populations. On September 30, 2009, the federal court in Memphis ruled in the State's favor on a particular point in the Arlington Developmental Center case. As a result of the ruling, the State is permitted to terminate a contract with Community Services Network for services that have been provided to members of the Arlington class and funded with pure state dollars. Instead, TennCare will deliver very similar services through this proposed amendment with TennCare Select. By making this change the state will be able to draw federal matching dollars which will permit us to serve a larger group of enrollees; those in the Arlington class and those individuals with MR who are enrolled in the other (non-Arlington associated) MR waivers or who are receiving care in a private ICF-MR. Per the plan presented to the court, individuals who currently meet the criteria previously noted will be given the option to "opt in" to TennCare Select as their MCO. New enrollees meeting such criteria will be assigned to TennCare Select with the ability to "opt out". TennCare Select will provide nurse care management services to this group of enrollees who have specialized health care needs.

Mr. Jim White
October 19, 2009

Additionally, TennCare is submitting for consideration proposed amendment #3 to Health Management Systems, Inc., TennCare's contract for the recovery of state funds resulting from third party payments. This competitively procured contract has resulted in millions of dollars in state recovery and the proposed amendment exercises the State's option to extend the term for the final year of the contract. No additional funding is required to support this term extension.

The Bureau of TennCare would greatly appreciate the consideration and approval of these contract amendments by the Fiscal Review Committee.

Sincerely,

Scott Pierce
Chief Financial Officer

cc: Darin J. Gordon, Deputy Commissioner
Alma Chilton, Contract Coordinator

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OCT 19 2009

FISCAL REVIEW

Supplemental Documentation Required for Fiscal Review Committee

*Contact Name:	Scott Pierce	*Contact Phone:	615-507-6415
*Contract Number:	FA-02-14632-00	*RFS Number:	318.66-026
*Original Contract Begin Date:	July 1, 2001	*Current End Date:	June 30, 2010
Current Request Amendment Number: *(if applicable)*	21		
Proposed Amendment Effective Date: *(if applicable)*	N/A		
*Department Submitting:	Department of Finance and Administration		
*Division:	Bureau of TennCare		
*Date Submitted:	October 19, 2009		
*Submitted Within Sixty (60) days:	Yes		
*If not, explain:			
*Contract Vendor Name:	Volunteer State Health Plan, Inc.		
*Current Maximum Liability:	$1,365,307,305.90		

*Current Contract Allocation by Fiscal Year:
(as Shown on Most Current Fully Executed Contract Summary Sheet)

FY: 2002	FY: 2003	FY: 2004	FY: 2005	FY 2006	FY 2007
$18,599,868.00	$33,079,942.00	$63,490,156.00	$116,014,894.00	$175,496,222.00	$175,496,222.00
FY: 2008	FY: 2009	FY: 2010			
$200,000,000.00	$200,000,000.00	$383,130,000.00			

*Current Total Expenditures by Fiscal Year of Contract:
(attach backup documentation from STARS or FDAS report - Attached)

FY: 2002	FY: 2003	FY: 2004	FY: 2005	FY 2006	FY 2007
$290,556,541.35	$413,769,656.17	$811,750,972.40	$990,250,679.53	$904,108,515.31	$929,733,206.66
FY: 2008	FY: 2009	FY: 2010			
$367,161,736.62	$382,499,549.22	$92,258,056.91			

IF Contract Allocation has been greater than Contract Expenditures, please give the reasons and explain where surplus funds were spent:	N/A
IF surplus funds have been carried forward, please give the reasons and provide the authority for the carry forward provision:	N/A
IF Contract Expenditures exceeded Contract Allocation, please give the reasons and explain how funding was acquired to pay the overage:	TennCare is obligated by contract to reimburse the Managed Care Organization for medical claims paid by the plan to providers and pay an administrative capitation payment per member to cover administrative costs. The maximum liability amounts for this contract represent the payments made by the state to the plan to provide claims processing and other administrative services for each fiscal year. The contract payments reported for each fiscal year represent both the medical claims reimbursement payments and the administrative payments to the plan.

*Contract Funding Source/Amount:	State:	$525,468,138.35	Federal:	$839,839,167.55	
Interdepartmental:			*Other:*		
If *"other"* please define:					

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Dates of All Previous Amendments or Revisions *(if applicable)*	Brief Description of Actions in Previous Amendments or Revisions *(if applicable)*
November 1, 2002	Amendment #1 – Language Modification, including changes to MCO language; Term Extension; Maximum Liability Increase
May 29, 2003	Amendment #2 - Language Modification, including changes to MCO language; Maximum Liability Increase
July 1, 2003	Amendment #3 – Language Modification, including changes to MCO language
November 14, 2003	Amendment #4 - Language Modification, including changes to MCO language; Maximum Liability Increase
December 15, 2003	Amendment #5 - Language Modification, including changes to MCO language; Maximum Liability Increase
January 1, 2004	Amendment #6 – Language Modification, including changes to MCO language; Term Extension; Maximum Liability Increase
July 1, 2004	Amendment #7 – Language Modification, including changes to MCO language
October 26, 2004	Amendment #8 - Language Modification, including changes to MCO language; Maximum Liability Increase
January 1, 2005	Amendment #9 – Language Modification, including changes to MCO language; Term Extension; Maximum Liability increase
May 18, 2005	Amendment #10 - Language Modification, including changes to MCO language; Maximum Liability Increase
July 1, 2005	Amendment #11 – Language Modification, including changes to MCO language
January 1, 2006	Amendment #12 – Language Modification, including changes to MCO language; Term Extension; Maximum Liability Increase
March 30, 2006	Amendment #13 – Language Modification, including changes to MCO language; Maximum Liability Increase
April 28, 2006	Amendment #14 – Language Modification, including changes to MCO language; Maximum Liability Increase
July 1, 2006	Amendment #15 – Language Modification, including changes to MCO language; Maximum Liability Increase
January 1, 2007	Amendment #16 - Language Modification, including changes to MCO language; Term Extension; Maximum Liability Increase
July 1, 2007	Amendment #17 - Language Modification, including changes to MCO language; Term Extension; Maximum Liability Increase
May 1, 2008	Amendment #18 – Language Modification, including changes to MCO language; Term Extension; Maximum Liability Increase
March 1, 2009	Amendment #19 – This amendment provided Shared Risk for Contractor, payment for Performance Measures, including EPSDT, Medical Service Budget Target, Case Manager Assignment, as well as establish bonus pool for shared risk initiative. The establishment of partial risk arrangements with managed care entities allows the state to claim a more favorable federal matching rate as well as properly align incentives between the State and the managed care entity.
July 1, 2009	Amendment #20 - This amendment extended the term and provided funds to support the term extension of existing services. Additionally, due to integration of behavioral services into the already existing medical service scope of service, this amendment provided language and funds to support this integration scheduled to begin September 1, 2009.
Method of Original Award *(if applicable)*	Non Competitive

Supplemental Documentation Required for Fiscal Review Committee

Pursuant to the request from the Fiscal Review Committee regarding additional information relative to Volunteer State Health Plan (TennCare Select) amendment #21, the following responses are submitted for consideration.

(1) **A detailed breakdown of the actual expenditures anticipated in each year of the contract, including specific line items, the source of funds (federal, state, or other--if other, please specify source), and the disposition of any excess funds.**

Actual expenditures are provided by enrollment rates by category as listed below. This contract is paid at Federal Financial Participation (FFP) rate, which differs from year to year. Fiscal Year 2010 FFP is State: .2586 % Federal: .7414 %

A detailed breakdown of anticipated expenditures and payment mechanisms for each year of the contract is listed below as stated in the contract language.

b. Effective January 1, 2003, the administrative fee paid for enrollees in Group 1.A, Group 1.B and Group 2 shall be $25.00 per member per month. **Effective July 1, 2006, the administrative fee paid for enrollees in Group 1.A, Group 1.B and Group 2 shall be $25.20 per member per month.**

c. Effective January 1, 2003, the administrative fee paid for enrollees in Group 3, Group 4, Group 5 and Group 6 shall vary based on the total number of enrollees in these groups as follows:

Enrollment Level	Administrative Fee
0 to 99,999 enrollees	$11.37
100,000 to 199,999 enrollees	$11.25
200,000 to 299,999 enrollees	$11.12
300,000 to 399,999 enrollees	$11.00
400,000 to 499,999 enrollees	$10.89
500,000 to 599,999 enrollees	$10.68
600,000 to 699,999 enrollees	$10.53
700,000 to 799,999 enrollees	$10.38
800,000 to 899,999 enrollees	$10.23
900,000 to 999,999 enrollees	$10.08
1,000,000 or more enrollees	$9.93

Effective July 1, 2006, the administrative fee paid for enrollees in Group 3, Group 4, Group 5 and Group 6 shall vary based on the total number of enrollees in these groups as follows:

Enrollment Level	Administrative Fee
0 to 99,999 enrollees	**$11.57**
100,000 to 199,999 enrollees	**$11.45**
200,000 to 299,999 enrollees	**$11.32**
300,000 to 399,999 enrollees	**$11.20**
400,000 to 499,999 enrollees	**$11.09**

500,000 to 599,999 enrollees	$10.88
600,000 to 699,999 enrollees	$10.73
700,000 to 799,999 enrollees	$10.58
800,000 to 899.999 enrollees	$10.43
900,000 to 999,999 enrollees	$10.28
1,000,000 or more enrollees	$10.13

i. The applicable administrative fee shall be determined based upon the total number of enrollees in the month preceding the month in which payment is made to the Contractor as determined by TENNCARE. The administrative fee specified shall be applicable to all enrollees in Group 3, Group 4, Group 5 and Group 6 upon attainment of an enrollment level. For example, if enrollment for the month of February is 250,000 enrollees, the administrative fee payment for the month of March shall be $11.12 per member per month for each Group 3, Group 4, Group 5 and Group 6 enrollee assigned to the CONTRACTOR during the month of March, adjusted as set forth in subparagraphs 5-1.d through 5-1.j, if applicable.

j. Pay-for-Performance Quality Incentive

On July 1, 2007 the CONTRACTOR will be eligible for an additional $0.03 pmpm, applied to member months from the period of July 1, 2006 to December 31, 2006, if their HEDIS 2007 HbA1C testing rate demonstrates significant improvement when compared to the MCO's 2006 HEDIS HbA1C testing rate. Significant improvement is defined using NCQA's minimum effect size change methodology and is illustrated in the following table where the CONTRACTOR's 2006 HEDIS HbA1C testing rate represents the baseline.

NCQA Minimum Effect Size Change Requirements:

Baseline Rate	Minimum Effect Size
0-59	At least a 6 percentage point change
60-74	At least a 5 percentage point change
75-84	At least a 4 percentage point change
85-92	At least a 3 percentage point change
93-96	At least a 2 percentage point change
97-99	At least a 1 percentage point change

In addition, on July 1, 2007, the CONTRACTOR will be eligible for another $0.03 pmpm applied to member months from the period of July 1, 2006 – December 31, 2006. This additional payment will be made if the CONTRACTOR's 2007 HEDIS Prenatal Care rate demonstrates significant improvement when compared to the MCO's 2006 HEDIS Prenatal Care rate. Significant improvement is defined using NCQA's minimum effect size change methodology and is illustrated in the table above where the MCO's 2006 HEDIS Prenatal Care rate represents the baseline.

On December 31, 2007, the CONTRACTOR will be eligible for an additional $0.03 pmpm applied to member months from January 1, 2007 – June 30, 2007 if the ED visit rate per 1000 for asthma has decreased by at least 5%. The time period for comparison will be January 1, 2007 – June 30, 2007 compared to a baseline represented by January 1, 2006, - June 30, 2006. Dual eligibles will be excluded from the rate numerator and denominator. Per methodology developed by the Bureau, only ED visits with asthma as a primary diagnosis will be included in the rate numerator. The rate denominator will

include individuals with asthma in any diagnosis field on any claim. Only individuals with continuous eligibility will be included in this calculation.

In addition, on December 31, 2007, the CONTRACTOR will be eligible for an another $0.03 pmpm applied to member months from January 1, 2007 – June 30, 2007 if the ED visit rate per 1000 for congestive heart failure has decreased by at least 5%. The time period for comparison will be January 1, 2007 – June 30, 2007 compared to a baseline represented by January 1, 2006, - June 30, 2006. Dual eligibles will be excluded from the rate numerator and denominator. Per methodology developed by the Bureau, only ED visits with congestive heart failure as a primary diagnosis will be included in the rate numerator. The rate denominator will include individuals with congestive heart failure in any diagnosis field on any claim. Only individuals with continuous eligibility will be included in this calculation.

On July 1, 2008, the CONTRACTOR will be eligible for a $0.03 pmpm payment, applied to member months from the period January 1, 2007 to December 31, 2007, for each of the following 2008 HEDIS or CAHPS measures for which significant improvement has been demonstrated. Significant improvement is defined using NCQA's minimum effect size change methodology, where the applicable 2007 HEDIS or CAHPS score serves as the baseline.

- **HbA1C Testing**
- **Controlling High Blood Pressure**
- **Timeliness of Prenatal Care**
- **Postpartum Care**
- **Adolescent Immunizations (combo2)**
- **Childhood Immunizations (combo 2)**
- **Cervical Cancer Screening**

k. **Shared Risk Terms and Conditions**

Effective March 1, 2009, the terms of the CONTRACTOR's shared risk responsibility shall be described below. The shared risk terms shall apply to the following populations as described in Section 4-1.1.a of this Contract: Group 1.A, Group 1.B, and Group 2.

The CONTRACTOR will be paid an administrative fee to administer the TennCare MCO benefits. Additionally, there will be both an upside potential (bonus) as well as downside potential (risk). Bonus and the risk will be based on the following components as described below:
EPSDT, and
Medical Services Budget Target.

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(1) **Acuity Adjustment**

The parties hereby agree that the aggregate base line acuity for the population administered by the CONTRACTOR shall be based on a methodology recommended by the State or its actuarial contractor.

The Parties further agree that the ability of the CONTRACTOR to achieve these initiatives is directly and materially related to said base line acuity of the aggregate population described above. As an integral part of evaluating the

CONTRACTOR's performance in achieving the goals set forth above, the CONTRACTOR and TennCare shall perform a quarterly follow-up acuity review of the aggregate population described above. The CONTRACTOR and

TennCare shall perform a reconciliation of aggregate acuity of the CONTRACTOR's assigned population described above and show compliance with the Shared Risk Initiatives adjusting for changes in acuity population and supply said adjustment data to TENNCARE for review and approval on a quarterly basis. The adjusted base line numbers for acuity shall serve as the standard for the determination as to whether the CONTRACTOR achieved the Shared Risk Initiatives.

(2) Mandates / Initiatives

In addition, the Parties hereby agree that the determination of achieving compliance with the above Shared Risk Initiatives shall be consistent with the obligations of this Contract as they are performed and interpreted as of March 1, 2009. As such, services provided as a result of compliance with an instruction or mandate from the TennCare Bureau that is in conflict with, or in excess of, those obligations pursuant to this Contract as of March 1, 2009 shall be taken into account and not counted against the Contractor in determining the achievement of the Shared Risk Initiatives.

(3) Risk Component

The Shared Risk Model will require that a percent of the administrative fees be placed at risk. The Model will set ten percent (10%) of the administrative fee at risk.

The Shared Risk Initiatives are listed below along with its associated risk contribution.

Shared Risk Initiative	Contribution to Risk
EPSDT Compliance	5.0%
Medical Services Budget Target	5.0%

(a) Increase EPSDT Compliance

The target for the period March 1, 2009 through June 30, 2009 is based on the CONTRACTOR's reported screening rate according to the information contained in the CMS 416 Report for FFY 2007 which is 85%.

The goal is to insure that all children under the age of twenty-one (21) are receiving screenings consistent with the periodicity schedule referenced in the Contract.

TENNCARE shall use the CMS 416 format in order to measure the CONTRACTOR's progress on a quarterly basis. In order to encourage continued progress, the administrative rate shall be reconciled in accordance with the following:

Percentage of EPSDT Compliance Benchmark	Administrative Fee Adjustment
≥ 100%	All admin assoc with EPSDT Screening rate compliance risk portion and potential

	bonus
≥ 95% and < 100%	-25% of admin assoc EPSDT Screening rate compliance risk portion
≥ 90% and < 95%	-50% of admin assoc EPSDT Screening rate compliance risk portion
≥ 85% and < 90%	-75% of admin assoc EPSDT Screening rate compliance risk portion
< 85% and lower	-100% of admin assoc EPSDT Screening rate compliance risk portion

Evaluation Period: Annually with a 90 day lag
At Risk Portion: 5.0% of Administrative Fee (Budget)
Implementation Date: March 1, 2009

(b) Medical Services Budget Target Initiative

At the end of the evaluation period associated with the MSBT, if the actual medical costs + IBNR is less than or equal to 100% of the MSBT, the CONTRACTOR shall retain 100% of the administrative fee associated with the MSBT. If the actual medical costs + IBNR is more than 100% of the MSBT, the CONTRACTOR's administrative fee associated with the MSBT shall be adjusted in accordance with the chart below. The estimated IBNR shall be reviewed and adjusted by the State's actuarial contractor prior to final determination of performance. The Table below illustrates the risk corridors for the Medical Services Budget target:

Percent of MSBT	Administrative Fee Adjustment
≤ 102%	All admin assoc with MSBT at risk portion and potential bonus
> 102% and ≤ 105%	-25% of admin assoc MSBT risk portion
> 105% and ≤ 110%	-50% of admin assoc MSBT risk portion
> 110% and ≤ 115%	-75% of admin assoc MSBT risk portion
> 115% and greater	-100% of admin assoc MSBT risk portion

Evaluation Period: Annual with a 90 day lag
At Risk Portion: 5% of Administrative Fee (Budget)
Implementation Date: March 1, 2009

(4) Performance Bonuses

TennCare will establish a bonus pool for each Risk Initiative described below. The bonus pool will represent a total of ten percent (10%) of the administrative fee for the selected population (Group 1.A, Group 1.B, and Group 2) for the CONTRACTOR as described in Section 5-1 of this Contract. The following Initiatives will be included in the Bonus Pool: EPSDT Compliance and Medical Service Budget Target (MSBT).

The following table identifies the weighting for each Initiative:

Shared Risk Initiative	Contribution to Bonus (% of Admin Rate for Selected Population)
EPSDT Compliance	5.0%
Medical Service Budget Target	5.0%

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Additional Bonus Points

Performance – Percent Exceeding Target	EPSDT Compliance Target
> 100% and ≤ 105%	25%
> 105% and ≤ 110%	60%
> 110% and ≤ 117%	100%

Performance – Percent Improving Target	Medical Services Budget Target
< 98% and ≥ 95%	25%
< 95% and ≥ 90%	50%
< 90% and ≥ 85%	75%
< 85%	100%

(5) Risk and Bonus Payout Reconciliation

The administrative fee will be paid in full on a monthly basis until such time the Evaluation Periods have occurred and determination has been made regarding the CONTRACTOR's compliance. Payouts for the annual evaluation period shall be made by October 31 of the following year.

In the event that the CONTRACTOR's progress on the various initiatives are different from what is determined by TennCare, the results (findings from both) will be reconciled during a fifteen (15) business day period following the due date of the submission by the Plan. If the dispute relates to medical cost and utilization based initiatives, TENNCARE shall request review by the Department of the Comptroller of the Treasury of said discrepancies. TennCare will submit an "On Request Report" (with a seven (7) day response time) to the CONTRACTOR in order for the CONTRACTOR to review and update or reprocess their data provided to TENNCARE. TENNCARE shall provide the outcome of the determination within eight (8) business days of receiving the information from the CONTRACTOR. If the information requested by TENNCARE is not provided by the due date, then the determination defaults to TENNCARE.

If targets are consistently exceeded (or not met) TENNCARE shall require that the CONTRACTOR submit a Corrective Action Plan to address the deficiencies.

Group 3, Group 4, Group 5 and **Group 6** shall vary based on the total number of enrollees in these groups as follows:

Administrative Fee Effective July 1, 2001 through December 31, 2002

Category	Effective July 1, 2001 – June 30, 2002	Effective July 1, 2002 – December 31, 2002
Group 1.A	$21.84 PMPM	$22.71 PMPM

Group 1.B	$21.84 PMPM	$22.71 PMPM
Group 2	$21.84 PMPM	$22.71 PMPM
Group 3	$13.84 PMPM	$14.39 PMPM
Group 4	$13.84 PMPM	$14.39 PMPM
Group 5	$13.84 PMPM	$14.39 PMPM
Group 6	$13.84 PMPM	$14.39 PMPM

II. Administrative Fee Effective January 1, 2003:

Group 1.A, Group 1.B, and **Group 2**

Category	**Effective January 1, 2003**
Group 1.A	$25.00 PMPM
Group 1.B	$25.00 PMPM
Group 2	$25.00 PMPM

Group 3, Group 4, Group 5 and **Group 6** shall vary based on the total number of enrollees in these groups as follows:

Enrollment Level	**Administrative Fee**
0 to 99,999 enrollees	$11.37
100,000 to 199,999 enrollees	$11.25
200,000 to 299,999 enrollees	$11.12
300,000 to 399,999 enrollees	$11.00
400,000 to 499,999 enrollees	$10.89
500,000 to 599,999 enrollees	$10.68
600,000 to 699,999 enrollees	$10.53
700,000 to 799,999 enrollees	$10.38
800,000 to 899.999 enrollees	$10.23
900,000 to 999,999 enrollees	$10.08
1,000,000 or more enrollees	$9.93

III. Administrative Fee Effective January 1, 2006:

Group 1.A, Group 1.B, and **Group 2**

Category	**Effective January 1, 2003**
Group 1.A	$25.20 PMPM
Group 1.B	$25.20 PMPM
Group 2	$25.20 PMPM

Group 3, Group 4, Group 5 and **Group 6** shall vary based on the total number of enrollees in these groups as follows:

Enrollment Level	**Administrative Fee**
0 to 99,999 enrollees	$11.57
100,000 to 199,999 enrollees	$11.45
200,000 to 299,999 enrollees	$11.32
300,000 to 399,999 enrollees	$11.20

400,000 to 499,999 enrollees	$11.09
500,000 to 599,999 enrollees	$10.88
600,000 to 699,999 enrollees	$10.73
700,000 to 799,999 enrollees	$10.58
800,000 to 899,999 enrollees	$10.43
900,000 to 999,999 enrollees	$10.28
1,000,000 or more enrollees	$10.13

IV. Administrative Fee Effective September 1, 2009

Category	Effective September 1, 2009
Group 1.A	$29.00 PMPM
Group 1.B	$29.00 PMPM
Group 2	$29.00 PMPM
Group 3	$29.00 PMPM
Group 4	$29.00 PMPM
Group 5	$29.00 PMPM
Group 6	$29.00 PMPM

4. **Attachment XVI shall be amended by adding a new item V which shall read as follows:**

V. Administrative Fee Effective Upon Implementation of the Integrated Health Services Delivery Model

Enrollee Category	Effective Upon Implementation of the Integrated Health Services Delivery Model
Group 1.A	$29.00 PMPM
Group 1.B	$29.00 PMPM
Group 2	$29.00 PMPM
Group 3	$29.00 PMPM
Group 4	$29.00 PMPM
Group 5[IHSDM]	TennCare shall reimburse actual and reasonable costs associated with the management and delivery of covered services for this population as specified in Section 4.1.6.
Group 5	$29.00 PMPM
Group 6	$29.00 PMPM

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(2) A detailed breakdown in dollars of any savings that the department anticipates will result from this contract, including but not limited to, reduction in positions, reduced equipment costs, travel, or any other item related to the contract.

TennCare Select provides medical services to thousands of TennCare enrollees across the state at contracted rates for medical services and associated administrative costs. Effective September 1, 2009, the contract began integrated services to include administration of behavioral health services to TennCare Select members as well. Integrating behavioral health services into the TennCare Select contract is not expected to increase costs related to providing behavioral health services for the Select population. This proposed amendment is adding a group of enrollees in the Arlington MR class who will receive very similar services through TennCare Select. By making this change the state will be able to draw federal matching dollars which will permit us to serve a larger group of enrollees - those in the Arlington Class and those individuals with MR who are enrolled in the other (non-Arlington associated) MR waivers or who are receiving care in a private ICF-MR.

(3) A detailed analysis in dollars of the cost of obtaining this service through the proposed contract as compared to other options.

The TennCare Select network was developed to create a consistent level of service through a group of providers to provide services to children in state custody and other high risk enrollees, as well as to provide a safety net should other managed care companies fail. At present, there is not another viable option to provide this network as it is currently configured. This amendment provides services to an increased population of enrollees as well as increases federal dollar match.

2002 TennCare Select Vendor payment

Vendor Numbe	Vendor Suffix	Amount
V621656610	00	290,556,541.35
	Total	**290,556,541.35**

2003 TennCare Select Vendor payment

Vendor Invoice	Warrant Number	Voucher	Amount
2002-69	P048785	091102NR2	9,392,524.07
2002-70	P055144	091702NR3	10,661,813.93
2002-71	P062257	092402NR4	7,105,264.99
2002-72	P068524	100102NR6	10,945,659.18
2002-73	P076150	100902NR3	8,681,617.84
2002-74	P083369	101502NR2	11,476,661.77
2002-75	P084274	101602NR2	652,206.19
2002-76	P089684	102202NR3	4,834,204.32
2002-77	P096569	102902NR4	15,849,505.83
2002-78	P102381	110502NR6	8,025,508.48
2002-79	P107483	111202NR5	12,226,470.95
2002-80	P116522	111902NR6	8,003,425.42
2002-81	P122933	112502NR2	10,523,735.41
2002-82	P128685	120302NR2	4,791,802.56
2002-83	P135702	121002NR4	12,182,299.13
2002-84	P145330	121702NR9	7,512,867.50
2002-85	P150215	122002NR1	11,070,533.38
2002-86	P155422	123102NR2	4,648,140.62
2003-01	P160508	010703NR5	10,357,303.58
2003-02	P170401	011403NR7	6,531,613.34
2003-03	P173689	012103NR3	9,669,481.84
2003-04	P179975	012803NR1	9,476,743.07
2003-06	P194464	021103NR5	8,234,543.23
2003-07	P202292	021803NR5	13,122,054.97
2003-08	P209638	022503NR3	8,191,323.02
2003-09	P216181	030403NR4	11,504,541.50
2003-10	P223739	031103NR4	8,245,497.34
2003-11	P232607	031803NR4	12,893,442.05
2003-12	P239494	032503NR6	7,425,841.02
2003-13	P246046	040103NR4	11,164,958.94
2003-14	P252368	040803NR7	7,709,575.34
2003-15	P253893	040903NR2	618,264.59
2003-16	P261104	041503NR6	12,491,593.75
2003-17	P266787	042203NR3	9,102,200.18
2003-18	P274218	042903NR4	10,904,296.01
2003-19	P280017	050603NR6	9,161,558.11
2003-20	P289403	051303NR3	12,467,903.24
2003-21	P295524	052003NR4	8,653,596.32

2003-22	P300931	052703NR4	10,678,761.95
2003-23	P308385	060303NR6	8,974,860.87
2003-24	P315549	061003NR4	12,942,681.44
2003-25	P324615	061703NR4	8,048,696.13
2003-25	P331612	062406NR2	15,661,878.76
2003-5	P186972	020403NR3	10,952,204.01
		Total	**413,769,656.17**

2004 TennCare Select Vendor payment

Vendor Invoice	Warrant Number	Voucher	Amount
2003-27	P339516	070103NR5	9,571,621.66
2003-28	P345419	070803NR4	12,901,141.70
2003-29	P356122	071503NR2	13,114,403.76
2003-30	P361788	072203NR4	10,612,921.84
2003-31	P367474	072903NR4	10,307,908.12
2003-36	P371129	080503NR9	13,384,066.87
2003-33	P377274	081203NR1	10,345,783.89
2003-34	P385856	081903NR6	11,143,261.05
2003-35	P394644	082793NR1	11,669,284.48
2003-36	P397991	090203NR3	11,586,532.73
2003-37	P404206	090903NR4	13,354,953.90
2003-38	P413180	091603NR6	12,633,269.91
2003-39	P420975	092403NR3	15,055,885.62
2003-40	P426714	093003NR6	15,798,808.77
2003-41	P432250	100703NR7	16,415,573.94
2003-41	P441025	101403NR2	(1,064,145.86)
2003-41-	P441025	101403NR2	1,064,145.86
2003-42	P441025	101403NR2	12,133,450.47
2003-42	P447099	102103NR6	44,179.16
2003-42-	P447099	102103NR6	48,915.83
2003-42--	P447099	102103NR6	(93,094.99)
2003-43	P447099	102103NR6	14,215,623.88
2003-43	P453627	102803NR4	20,944.70
2003-43-	P453627	102803NR4	1,039,913.89
2003-43--	P453627	102803NR4	(1,060,858.59)
2003-44	P453627	102803NR4	17,621,780.18
2003-44	P460688	110403NR4	190,334.85
2003-44-	P460688	110403NR4	1,388,563.91
2003-44--	P460688	110403NR4	(1,578,898.76)
2003-45	P460688	110403NR4	13,707,170.77
2003-45	P468670	111203NR2	187,475.89
2003-45-	P468670	111203NR2	797,122.56
2003-45--	P468670	111203NR2	(984,598.45)
2003-46	P468670	111203NR2	15,809,075.76
2003-47	P475333	111803NR4	13,929,696.52
2003-46	P483097	112503NR4	47,781.35
2003-46-	P483097	112503NR4	680,591.02
2003-46--	P483097	112503NR4	(728,372.37)
2003-47	P483097	112503NR4	39,309.50
2003-47-	P483097	112503NR4	638,481.33
2003-47--	P483097	112503NR4	(677,790.83)

2003-48	P483097	112503NR4	14,974,277.93
2003-48	P487383	120203NR5	22,442.87
2003-48-	P487383	120203NR5	554,454.74
2003-48--	P487383	120203NR5	(576,897.61)
2003-49	P487383	120203NR5	8,306,089.43
2003-49	P494604	120903NR4	16,059.06
2003-49-	P494604	120903NR4	158,530.34
2003-49--	P494604	120903NR4	(174,589.40)
2003-50	P494604	120903NR4	18,352,281.27
2003-50	P504141	121603NR6	37,740.06
2003-50-	P504141	121603NR6	664,415.90
2003-50--	P504141	121603NR6	(702,155.96)
2003-51	P504141	121603NR6	15,726,068.53
2003-51	P510184	122203NR4	86,270.36
2003-51-	P510184	122203NR4	1,144,550.20
2003-51--	P510184	122203NR4	(1,230,820.56)
2003-52	P510184	122203NR4	16,430,966.73
2003-52	P515582	123003NR4	27,506.84
2003-52-	P515582	123003NR4	592,937.23
2003-52--	P515582	123003NR4	(620,444.07)
2003-53	P515582	123003NR4	8,721,987.07
2003-53	P520061	010604NR6	18,625.59
2003-53-	P520061	010604NR6	92,378.82
2003-53--	P520061	010604NR6	(111,004.41)
2004-01	P520061	010604NR6	13,000,161.88
2004-01	P529928	011304NR3	21,753.95
2004-01-	P529928	011304NR3	597,456.99
2004-01--	P529928	011304NR3	(619,210.24)
2004-02	P529928	011304NR3	17,546,494.22
2004-02	P535078	012004NR7	63,928.89
2004-02-	P535078	012004NR7	121,655.31
2004-02--	P535078	012004NR7	(185,584.20)
2004-03	P535078	012004NR7	12,868,081.59
2004-03	P549037	020304NR2	10,921.60
2004-03-	P549037	020304NR2	(1,232,670.30)
2004-03--	P549037	020304NR2	1,221,748.70
2004-04	P549037	020304NR2	31,813.28
2004-04-	P549037	020304NR2	357,666.44
2004-04--	P549037	020304NR2	(389,479.72)
2004-05	P549037	020304NR2	16,260,359.96
2004-05	P556339	021004NR6	26,900.83
2004-05-	P556339	021004NR6	305,930.03
2004-05--	P556339	021004NR6	(332,830.86)
2004-06	P556339	021004NR6	18,970,284.89
2004-04	P541761	012704NR5	4,214,773.78
2004-04-	P541761	012704NR5	15,221,252.76
2004-06	P564496	021704NR7	13,238.83

2004-06-	P564496	021704NR7	142,442.76
2004-06--	P564496	021704NR7	(155,681.59)
2004-07	P564496	021704NR7	17,080,163.52
2004-07	P571198	022404NR5	27,734.97
2004-07-	P571198	022404NR5	264,361.31
2004-07--	P571198	022404NR5	(292,096.28)
2004-08	P571198	022404NR5	19,656,057.63
2004-08	P578797	030204NR4	61,776.64
2004-08-	P578797	030204NR4	198,077.82
2004-08--	P578797	030204NR4	(259,854.46)
2004-09	P578797	030204NR4	17,932,603.38
2004-09	P586386	030904NR5	11,330.72
2004-09-	P586386	030904NR5	191,673.51
2004-09--	P586386	030904NR5	(203,004.23)
2004-10	P586386	030904NR5	19,480,654.91
2004-10	P595341	031604NR4	24,364.27
2004-10-	P595341	031604NR4	213,986.50
2004-10--	P595341	031604NR4	(238,350.77)
2004-11	P595341	031604NR4	16,739,640.17
2004-11	P602609	032304NR2	6,301.60
2004-11-	P602609	032304NR2	247,131.18
2004-11--	P602609	032304NR2	(253,432.78)
2004-12	P602609	032304NR2	18,786,140.00
2004-13	P610025	033004NR5	16,268,602.11
2004-14	P616395	040604NR6	18,831,995.00
2004-15	P624541	041304NR3	19,185,757.42
2004-16	P631569	042004NR4	18,113,523.24
2004-17	P638012	042704NR4	16,946,800.75
2004-18	P645376	050404NR4	19,902,428.14
2004-19	P652258	051104NR3	18,259,754.23
2004-20	P661472	051804NR6	17,738,461.86
2004-20	P668376	052504NR8	(400.00)
2004-21	P668376	052504NR8	16,691,824.67
2004-20	Q001625	052704NR2	400.00
2004-22	Q004096	060104NR3	15,043,406.35
2004-23	Q011105	060804NR4	17,669,270.69
2004-24	Q020959	061504NR5	18,459,311.35
2004-25	Q027081	062204NR2	16,249,722.14
2004-26	Q036035	062904NR4	16,809,558.28
		Total	**811,750,972.40**

2005 TennCare Select Vendor payment

Vendor Invoice	Warrant Number	Voucher	Amount
2004-27	Q042367	070604NR4	13,805,308.23
2004-28	Q043815	070704NR3	1,101,601.81
2004-29	Q053375	071304NR3	17,536,614.77
2004-30	Q059096	072004NR7	17,140,846.34
2004-31	Q063466	072704NR5	21,768,665.01
2004-32	Q069516	080304NR5	17,137,689.89
2004-33	Q075332	081004NR4	20,267,480.86
2004-34	Q084930	081704NR7	18,850,281.71
2004-35	Q092202	082404NR1	17,899,784.19
2004-36	Q099296	083104NR6	19,478,023.19
2004-37	Q104552	090704NR3	18,189,723.57
2004-38	Q113644	091404NR3	16,131,772.44
2004-39	Q120552	092104NR4	19,026,751.60
2004-40	Q127527	092804NR4	20,018,213.38
2004-41	Q134297	100504NR2	18,684,861.89
2004-42	Q141101	101204NR4	18,865,004.09
2004-43	Q150261	101904NR4	15,540,616.56
2004-44	Q157406	102604NR3	25,601,222.15
2004-45	Q165051	110204NR3	18,651,988.03
2004-46	Q170459	110804NR3	17,706,671.30
2004-47	Q180475	111604NR3	16,498,772.25
2004-47B	Q183568	111804NR1	639,879.31
2004-47	Q186373	112204NR2	19,938,964.52
2004-48B	Q189943	112404NR1	853,051.24
2004-49	Q192986	113004NR4	12,286,193.56
2004-50	Q200656	120704NR3	23,229,410.67
2004-51	Q210927	121404NR5	22,942,631.44
2004-52	Q217109	122204NR2	23,469,595.61
2004-53	Q222329	122804NR3	7,384,351.21
2005-01	Q226563	010405NR3	16,083,818.43
2005-02	Q233515	011105NR3	19,578,867.41
2005-03	Q241962	011805NR4	19,607,510.32
2005-04	Q249534	012505NR4	25,823,785.87
2005-05	Q257430	020105NR1	21,368,292.95
2005-06	Q264106	020805NR3	21,654,011.13
2005-07	Q274350	021505NR5	19,863,749.95
2005-08	Q279857	022205NR6	20,615,380.60
2005-07	Q287730	030105NR2	1,089.22
2005-08	Q287730	030105NR2	(1,089.22)
2005-09	Q287730	030105NR2	22,193,003.63
2005-10	Q295874	030805NR4	21,216,557.65
2005-11	Q306182	031505NR2	21,699,893.04
2005-12	Q313549	032205NR2	18,831,307.75
2005-12	Q319248	032905NR4	17,992,341.46
2005-14	Q326639	040505NR3	19,659,202.06
2005-15	Q333302	041205NR1	18,677,731.22
2005-16	Q343240	041905CO6	19,104,939.58
2005-17	Q349882	042605NR2	26,598,290.01
2005-18	Q358432	050305NR1	20,929,323.29

2005-19	Q365115	051005NR2	21,641,385.00
2005-20	Q374441	051705NR4	20,077,386.14
2005-21	Q381801	052405NR2	20,658,158.17
2005-22	Q388730	053105NR2	18,712,519.87
2005-23	Q395119	060705NR4	18,369,808.05
2005-24	Q405289	061405NR4	20,951,295.23
2005-25	Q412166	062105NR3	19,675,061.20
2005-26	Q419968	062805NR2	19,720,981.74
		Total	**990,250,679.53**

2006 TennCare Select Vendor payment

Vendor Invoice	Voucher	Amount
2005-30	072605NR5	23,530,975.71
2006-04	012406NR2	21,749,449.95
2006-17	042506NR2	21,369,311.52
2005-49	120605NR2	20,606,440.88
2005-29	071905NR3	20,570,935.54
2005-27	070505NR2	20,221,130.26
2006-11	031406NR3	20,197,818.45
2006-26	062706NR3	19,986,895.01
2005-43	102505NR4	19,691,508.89
2005-33	081605NR4	19,498,944.07
2005-51	122005NR2	19,154,057.50
2005-32	080905NR3	19,095,632.45
2006-12	032106NR1	18,990,278.17
2005-47	112105NR2	18,925,878.75
2005-28	071205NR4	18,881,877.95
2006-06	020706NR3	18,556,398.83
2005-50	121305NR2	18,235,062.26
2005-35	083005NR3	18,196,655.52
2006-05	013106NR4	18,186,584.61
2005-46	111505NR4	18,153,665.40
2006-09	022806NR2	18,121,797.95
2006-19	050906NR4	18,120,001.07
2005-40	100405NR2	18,000,182.53
2005-31	080205NR3	17,928,609.59
2006-24	061306NR3	17,830,061.44
2005-45	110805NR1	17,805,545.42
2005-36	090605NR3	17,630,949.44
2005-44	110105NR1	17,567,158.81
2006-14	040406NR3	17,507,708.45
2005-34	082305NR4	17,383,004.25
2006-20	051606NR5	17,220,456.87
2006-03	011706NR4	17,051,015.51
2005-36	091305NR2	16,999,409.92
2006-08	022106NR5	16,983,748.18
2005-39	092705NR2	16,968,298.94
2006-10	030706NR2	16,953,239.25
2006-13	032806NR1	16,850,998.03
2005-42	101805NR1	16,609,270.69
2006-07	021406NR1	16,525,382.24
2006-21	052306NR3	16,260,689.37
2005-38	092005NR3	16,074,495.63

2006-18	050206NR1	16,042,283.90
2006-15	041106NR3	15,975,611.17
2006-15	041806NR4	15,448,206.81
2006-01	010306NR3	15,306,476.97
2006-25	062006NR2	15,305,684.66
2006-22	053006NR2	15,217,720.36
2006-02	011006NR4	14,563,137.47
2005-52	122705NR5	14,001,360.40
2005-41	101105NR1	13,601,677.80
2005-48	112905NR2	10,676,650.10
2005-45B	100905NR1	1,778,180.37
	Total	**904,108,515.31**

2007 TennCare Select Vendor payment

Vendor Invoice	Invoice Date	Voucher	Amount
2006-26		070306NR2	0.00
2006-27		070306NR2	16,262,352.83
2006-28		071106NR2	15,644,024.82
2006-29		071806NR1	17,005,130.42
2006-30		072606NR2	24,731,415.08
2006-31		080106NR3	16,996,699.73
2006-32	8/8/2006	080906NR2	17,248,515.67
2006-33	8/15/2006	081606NR3	16,577,975.95
2006-34	8/22/2006	082206NR2	17,614,658.55
2006-35	8/29/2006	083006NR3	18,917,975.73
2006-36	9/5/2006	090506NR4	17,210,552.58
2006-37	9/12/2006	091206NR3	13,301,832.88
2006-38	9/19/2006	091906NR3	20,320,994.67
2006-39	9/26/2006	092606NR3	22,180,915.29
2006-40	10/3/2006	100306NR5	23,463,094.52
2006-41	10/10/2006	101006NR2	17,651,414.72
2006-42		101706NR2	16,052,176.14
2006-43	10/24/2006	102406NR2	21,287,276.20
2006-44	10/31/2006	103106NR2	16,248,943.11
2006-45	11/7/2006	110706NR1	22,366,180.20
2006-46	11/14/2006	111406NR4	24,435,987.79
110306	8/23/2006	110606OT1	918,644.43
2006-47	11/20/2006	112006NR2	22,534,216.51
2006-48	11/28/2006	112806NR4	10,768,460.11
2006-49	12/5/2006	120506NR5	25,263,087.62
2006-50	12/12/2006	121206NR5	22,549,726.25
2006-51	12/19/2006	121906NR3	18,261,656.72
2006-52	12/27/2006	122706NR2	18,819,656.44
2007-01	1/2/2007	010207NR4	12,060,139.25
2007-02	1/9/2007	010907NR4	15,822,481.58
2007-03	1/16/2007	011607NR4	19,138,300.02
2007-04	1/23/2007	012307NR3	23,463,730.71
2007-05	1/30/2007	013007NR1	23,425,253.78
2007-06	2/6/2007	020607NR4	20,550,165.93
2007-07	2/13/2007	021307NR2	21,310,244.65
2007-08	2/20/2007	022007NR3	21,145,908.60
2007-09	2/27/2007	022707NR4	28,205,782.76
2007-10	3/6/2007	030607NR2	25,383,408.26
2007-11	3/12/2007	031307NR4	21,670,981.00
2007-12	3/20/2007	032007NR4	22,471,345.50
2007-13	3/27/2007	032707NR5	22,221,662.46
2007-14	4/3/2007	040307NR1	20,444,321.61
2007-15	4/9/2007	041007NR2	21,498,656.91
2007-16	7/16/2007	041707NR1	13,929,180.68
2007-17	4/24/2007	042407NR3	18,684,036.40
2007-18	4/30/2007	050107NR4	11,658,711.12
2007-19	5/8/2007	050807NR3	12,041,186.08
2007-20	5/14/2007	051507NR1	11,253,604.12
2007-21	5/21/2007	052207NR1	10,302,073.28
2007-22	5/29/2007	052907NR1	8,392,623.79
2007-23	6/4/2007	060507NR2	8,727,679.58
2007-24	6/11/2007	061207NR2	8,078,652.35
2007-25	6/18/2007	061907NR2	6,843,275.21
2007-26	6/26/2007	062607NR3	6,376,236.07
		Total	**929,733,206.66**

2008 TennCare Select Vendor payment

Vendor Invoice	Invoice Date	Voucher	Amount
TPL ADMIN FY08	3/24/2008	032408OT1	590,773.18
2008-01	7/2/2007	070207NR1	8,874,275.93
RATE ADJUST	7/5/2007	070507NR1	13,787,598.00
2008-02	7/9/2007	071007NR1	5,862,696.71
2008 03	7/17/2007	071707NR3	5,278,216.47
2008-04	7/23/2007	072407NR1	9,237,287.76
2008-05	7/31/2007	073107NR6	8,314,595.68
2008-06	8/6/2007	080607NR2	7,923,631.92
2008-07	8/13/2007	081407NR3	7,063,107.76
2008-08	8/20/2007	082107NR5	6,923,114.68
2008-09	8/28/2007	082807NR6	8,590,631.40
2008-10	9/4/2007	090407NR3	5,649,195.03
2008-11	9/10/2007	091107NR3	5,530,250.23
TPL ADMIN	9/14/2007	091407OT1	1,714,667.19
2008-12	9/17/2007	091807NR4	7,186,374.44
2008-13	9/25/2007	092507NR4	7,030,873.28
2008-14	10/2/2007	100207NR2	5,934,061.15
2008-15	10/8/2007	100907NR4	7,013,158.67
NCQA	10/2/2007	100507OT1	134,407.00
2008-16	10/15/2007	101607NR3	6,353,278.06
2008-17	10/22/2007	102307NR5	9,752,014.63
2008-18	10/29/2007	103007NR2	6,301,810.58
2008-19	11/5/2007	110607NR5	7,064,685.71
2008-20	11/13/2007	111307NR6	8,087,177.98
2008-21	11/19/2007	111907NR4	7,034,463.56
2008-22	11/26/2007	112607NR2	4,595,460.36
2008-23	12/4/2007	120407NR5	9,398,864.85
2008-24	12/10/2007	121107NR4	7,183,459.36
2008-25	12/17/2007	121807NR3	7,665,163.71
2008-26	12/26/2007	122607NR3	6,970,653.72
2008-27	1/2/2008	010208NR5	3,815,524.43
2008-28	1/7/2008	010807NR4	3,993,418.36
2008-29	1/14/2008	011508NR3	7,495,270.98
2008-30	1/22/2008	012208NR4	8,933,348.49
2008-31	1/28/2008	012908NR4	6,605,308.64
2008-32	2/5/2008	020508NR3	6,030,307.08
2008-33	2/11/2008	021208NR4	5,571,950.15
2008-34	2/19/2008	021908NR5	5,844,930.94
2008-35	2/25/2008	022608NR4	6,953,700.04
2008-36	3/3/2008	030408NR5	6,105,078.86
2008-37	3/11/2008	031108NR3	7,201,578.61
2008-38	3/17/2008	031808NR4	6,852,789.47
2008-39	3/24/2008	032508NR4	6,816,851.20
2008-40	3/31/2008	040108NR5	6,481,683.64
2008-41	4/8/2008	040808NR3	6,004,251.78
2008-42	4/15/2008	041508NR5	6,900,640.94

2008-43	4/22/2008	042208NR4	9,390,994.69
2008-44	4/29/2008	042908NR4	5,349,680.76
2008-45	5/5/2008	050608NR3	6,731,103.10
2008-46	5/13/2008	051308NR2	6,227,000.38
2008-47	5/20/2008	052008NR3	6,526,640.19
2008-48	5/27/2008	052708NR4	6,904,841.81
2008-49	6/3/2008	060308NR5	4,813,399.62
2008-50	6/10/2008	061008NR4	5,277,854.26
2008-51	6/17/2008	061708NR4	5,188,273.42
2008-52	6/23/2008	062408NR4	6,099,365.78
		Total	**367,161,736.62**

2009 Select All Vendor Payment

Vendor Invoice	Invoice Date	Voucher	Total
TPL Q3 FY 08	7/16/2008	071608OT1	[illegible]
TPL QTR 4 FY08	8/14/2008	081408OT2	[illegible]
VSHP200812	12/31/2008	022509CO2	[illegible]
ADMIN PYMT	2/26/2009	032309OT1	[illegible]
VSHP200901	1/31/2009	032609CO1	[illegible]
RA100297726	7/1/2008	100297726	[illegible]
RA100297728	7/1/2008	100297728	[illegible]
TPL Q3 FY 08	7/16/2008	071608OT2	[illegible]
TPL QTR 4 FY08	8/14/2008	081408OT1	[illegible]
CRA100356632	9/2/2008	100356632	[illegible]
RA100356632	9/2/2008	100356632	[illegible]
RA100356633	9/2/2008	100356633	[illegible]
RA100383426	9/30/2008	100383426	[illegible]
RA100383427	9/30/2008	100383427	[illegible]
CRA100417534	11/4/2008	100417534	[illegible]
RA100417534	11/4/2008	100417534	[illegible]
RA100417535	11/4/2008	100417535	[illegible]
RA100444525	12/2/2008	100444525	[illegible]
RA100444526	12/2/2008	100444526	[illegible]
RA100471378	12/29/2008	100471378	[illegible]
CRA100471378	12/29/2008	100471378	[illegible]
RA100471379	12/29/2008	100471379	[illegible]
CRA100505483	2/3/2009	100505483	[illegible]
RA100505483	2/3/2009	100505483	[illegible]
RA100505484	2/3/2009	100505484	[illegible]
RA100533140	3/3/2009	100533140	[illegible]
RA100533141	3/3/2009	100533141	[illegible]
RA100561123	3/31/2009	100561123	[illegible]
RA100561124	3/31/2009	100561124	[illegible]
CRA100323082	7/29/2008	100323082	[illegible]
RA100323082	7/29/2008	100323082	[illegible]
RA100323083	7/29/2008	100323083	[illegible]
CRA100626257	6/2/2009	100626257	[illegible]
2009-01	7/1/2008	070108NR6	[illegible]
2009-02	7/8/2008	070808NR3	[illegible]
2009-03	7/15/2008	071508NR4	[illegible]
2009-04	7/22/2008	072208NR3	[illegible]
2009-05	7/29/2008	072908NR5	[illegible]
2009-06	8/5/2008	080508NR4	[illegible]
2009-07	8/12/2008	081208NR5	[illegible]
2009-08	8/19/2008	081908NR5	[illegible]
2009-09	8/26/2008	082608NR5	[illegible]
2009-10	9/2/2008	090208NR3	[illegible]
2009-11	9/9/2008	090908NR5	[illegible]
2009-12	9/16/2008	091608NR4	[illegible]
2009-13	9/23/2008	092308NR5	[illegible]
2009-14		093008NR2	[illegible]

2009-15	10/7/2008	100708NR1	6,051,519.89
2009-16	10/14/2008	101408NR2	6,013,149.33
2009-17	10/21/2008	102108NR5	6,840,471.45
2009-18	10/28/2008	102808NR2	7,836,284.21
2009-19	11/4/2008	110408NR3	5,891,777.12
2009-20	11/12/2008	111208NR2	6,743,829.22
2009-21	11/18/2008	111808NR4	5,877,857.68
2009-22	11/24/2008	112408NR2	6,736,420.98
2009-23	12/2/2008	120208NR1	7,166,410.39
2009-24	12/9/2008	120908NR4	8,059,739.71
2009-25	12/16/2008	121608NR2	6,827,111.51
2009-26	12/22/2008	122208NR2	6,085,475.35
2009-27	12/29/2008	122908NR2	5,495,799.07
2009-28	1/6/2009	010609NR2	4,698,051.72
2009-29	1/13/2009	011309NR5	7,950,522.69
2009-30	1/20/2009	012009NR5	8,349,147.23
2009-31	1/27/2009	012709NR2	9,999,136.43
2009-32	2/3/2009	020309NR2	7,377,147.18
2009-33	2/10/2009	021009NR3	6,611,999.63
2009-34	2/17/2009	021709NR4	6,001,249.78
2009-35	2/24/2009	022409NR5	5,826,233.29
2009-36	3/3/2009	030309NR5	6,143,426.43
2009-37	3/10/2009	031009NR4	8,186,892.04
2009-38	3/17/2009	031709NR2	6,503,399.07
2009-39	3/24/2009	032409NR4	7,813,842.97
2009-40	3/31/2009	033109NR6	8,333,843.37
2009-41	4/7/2009	040709NR3	6,823,896.66
2009-42	4/14/2009	041409NR4	5,098,047.14
2009-43	4/21/2009	042109NR2	7,028,486.62
2009-44	4/28/2009	042809NR2	8,368,322.78
2009-45	5/5/2009	050509NR5	8,671,028.90
2009-46	5/12/2009	051209NR3	5,483,584.73
2009-47	5/19/2009	051909NR7	8,696,476.71
2009-48	5/26/2009	052609NR5	5,837,479.99
2009-49	6/2/2009	060209NR3	7,132,453.99
2009-50	6/9/2009	060909NR3	6,287,183.36
2009-51	6/16/2009	061609NR8	7,360,824.37
2009-52	6/23/2009	062309NR5	6,014,686.34
2010-01	6/30/2009	063009NR1	6,761,745.29
VSHP 200902	2/28/2009	041409CO2	(39,244.00)
VSHP 200904	4/30/2009	070809CO4	0.00
VSHP 200905	5/31/2009	070809CO4	0.00
RA100590399	4/28/2009	100590399	135,505.33
CRA100590399	4/28/2009	100590399	(47,000.00)
RA100590400	4/28/2009	100590400	1,518,060.08
RA100626257	6/2/2009	100626257	142,187.06
CRA100626257	6/2/2009	100626257	(43,927.16)
RA100626258	6/2/2009	100626258	1,528,365.82
Total			182,409,849.22

2010 Select All Vendor Payment

Report Filter:
"07") And ({Effective Year} (YYYY) = 2010)

Vendor Invoice	Invoice Date	Voucher	Total Vendor Disbursements
VSHP 200904	4/30/2009	070809CO4	[illegible]
VSHP 200905	5/31/2009	070809CO4	[illegible]
RA 957			[illegible]
CR 3957			[illegible]
RA100653958	6/29/2009	100653958	[illegible]
RA100689583	8/4/2009	100689583	[illegible]
CRA100689583	8/4/2009	100689583	[illegible]
RA100689584	8/4/2009	100689584	[illegible]
RA100718545	9/1/2009	100718545	[illegible]
RA100718546	9/1/2009	100718546	[illegible]
2010-02	7/7/2009	070709NR2	[illegible]
2010-03	7/14/2009	071409NR4	[illegible]
2010-04	7/21/2009	072109NR6	[illegible]
2010-05	7/28/2009	072809NR2	[illegible]
2010-06	8/4/2009	080409NR4	[illegible]
2010-07	8/11/2009	081109NR4	[illegible]
2010-08	8/18/2009	081809NR5	[illegible]
2010-09	8/25/2009	082509NR4	[illegible]
2010-10	9/1/2009	090109NR5	[illegible]
2010-11	9/10/2009	00000002	[illegible]
2010-12	9/17/2009	00001305	[illegible]
2010-13	9/24/2009	00002886	[illegible]
2010-14	10/1/2009	00004772	[illegible]
Total			[illegible]

REQUEST: NON-COMPETITIVE AMENDMENT

APPROVED
Commissioner of Finance & Administration Date:

Each of the request items below indicates specific information that must be individually detailed or addressed as required. A REQUEST CAN NOT BE CONSIDERED IF INFORMATION PROVIDED IS INCOMPLETE, NON-RESPONSIVE, OR DOES NOT CLEARLY ADDRESS EACH OF THE REQUIREMENTS INDIVIDUALLY AS REQUIRED.			
RFS #:	318.66-026		
STATE AGENCY NAME:	Department of Finance and Administration, Bureau of TennCare		
SERVICE CAPTION:	Provides TennCare Covered Medical and Behavioral Services to Children in State Custody and Other High Risk Enrollees		
CONTRACT #:	FA-02-14632-00	**PROPOSED AMENDMENT #:**	21
CONTRACTOR:	Volunteer State Health Plan, Inc.		
CONTRACT START DATE:	July 1, 2001		
CURRENT, LATEST POSSIBLE END DATE: (including ALL options to extend):	06/30/2010		
CURRENT MAXIMUM LIABILITY:	$1,365,307,305.90		
LATEST POSSIBLE END DATE WITH PROPOSED AMENDMENT: (including ALL options to extend)	06/30/2010		
TOTAL MAXIMUM COST WITH PROPOSED AMENDMENT: (including ALL options to extend)	$1,382,683,905.90		
APPROVAL CRITERIA: (select one)	☒ **use of Non-Competitive Negotiation is in the best interest of the state**		
	☐ **only one uniquely qualified service provider able to provide the service**		
ADDITIONAL REQUIRED REQUEST DETAILS BELOW (address each item immediately following the requirement text)			
(1) description of the proposed additional service and amendment effects:			

This amendment is as a result of a court ruling that permits the State to terminate a contract with Community Services Network for services that have been provided to members of the Arlington class and funded with pure state dollars. Instead, TennCare will deliver very similar services through TennCare Select. By making this change the state will be able to draw federal matching dollars which will permit us to serve a larger group of enrollees - those in the Arlington class and those individuals with MR who are enrolled in the other (non-Arlington associated) MR waivers or who are receiving care in a private ICF-MR. Per the plan presented to the court, individuals who currently meet the criteria previously noted will be given the option to "opt in" to TennCare Select as their MCO. New enrollees meeting such criteria will be assigned to TennCare Select with the ability to "opt out". TennCare Select will provide nurse care management services to this group of enrollees who have specialized health care needs.

(2) explanation of need for the proposed amendment :

This amendment will allow services to be provided to a larger group of enrollees and do so with an increase in the federal matching dollars that can be drawn.

(3) name and address of the proposed contractor's principal owner(s) :
(not required if proposed contractor is a state education institution)

BlueCross BlueShield 801 Pine St Chattanooga,TN 37402

(4) documentation of OIR endorsement of the Non-Competitive procurement request :
(required only if the subject service involves information technology)

select one:	☒ Documentation Not Applicable to this Request	☐ Documentation Attached to this Request

(5) documentation of Department of Personnel endorsement of the Non-Competitive procurement request :
(required only if the subject service involves training for state employees)

select one:	☒ Documentation Not Applicable to this Request	☐ Documentation Attached to this Request

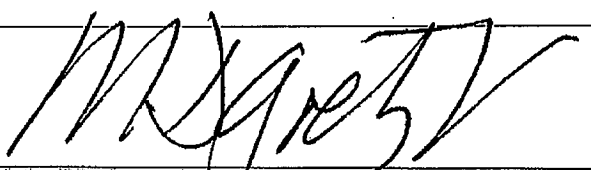
(6) description of procuring agency efforts to identify reasonable, competitive, procurement alternatives rather than to use non-competitive negotiation :

This Contractor is currently providing a network of medical and behavioral services for the TennCare Program. This amendment allows the State to add MR enrollees with special care needs that are currently being served to the Select contract and allow for a greater federal dollar match.

(7) justification of why the F&A Commissioner should approve a Non-Competitive Amendment :

The Bureau of TennCare received a ruling by the federal court that permits the State to terminate a contract with Community Services Network for services that are being provided to members of the Arlington class and funded with State dollars. TennCare is amending the Select contract to move these enrollees as well as those individuals with MR who are enrolled in the other (non-Arlington) MR waivers, allowing for the opportunity to serve a greater number of enrollees, as well as receiving a greater match of federal dollars for these enrollees. TennCare would greatly appreciate approval by the Commissioner of Finance and Administration.

AGENCY HEAD REQUEST SIGNATURE:
(must be signed by the ACTUAL procuring agency head as detailed on the Signature Certification on file with OCR — signature by an authorized signatory will be accepted only in documented exigent circumstances)



SIGNATURE DATE:

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026	Contract Number:	FA-02-14632-21
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare

Contractor	Contract Identification Number
VSHP (TennCare Select)	☐ V- ☐ C-

Service Description

Managed Care Organization / Medically Necessary Health Care Services to the TennCare

Contract Begin Date	Contract End Date
7/1/2001	6/30/2010

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	4A2	134	11	☐ STARS		

FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments
2002	$ 6,755,937.23	$ 11,843,931.25			$ 18,599,868.48
2003	$ 15,785,123.40	$ 17,294,819.40			$ 33,079,942.80
2004	$ 25,125,990.72	$ 38,364,165.90			$ 63,490,156.62
2005	$ 58,007,447.00	$ 58,007,447.00			$ 116,014,894.00
2006	$87,748,111.00	$87,748,111.00			$175,496,222.00
2007	$87,748,111.00	$87,748,111.00			$175,496,222.00
2008	$72,610,000.00	$127,390,000.00			$200,000,000.00
2009	$72,610,000.00	$127,390,000.00			$200,000,000.00
2010	$99,786,219.00	$300,720,381.00			$400,506,600.00
Total:	$ 526,176,939.35	$ 856,506,966.55			$1,382,683,905.90

CFDA#	93.778 Title XIX Dept. of Health &Human Svcs.

State Fiscal Contract

Name:	Scott Pierce
Address:	310 Great Circle Road
Phone:	Nashville, TN (615)507-6415

Procuring Agency Budget Officer Approval Signature

Scott Pierce

Check the box ONLY if the answer is YES:

Is the Contractor a SUBRECIPIENT? (per OMB A-133)	
Is the Contractor a Vendor? (per OMB A-133)	
Is the Fiscal Year Funding STRICTLY LIMITED?	
Is the Contractor on STARS?	
Is the Contractor's FORM W-9 ATTACHED?	
Is the Contractor's Form W-9 Filed with Accounts?	

COMPLETE FOR ALL AMENDMENTS (only)

	Base Contract & Prior Amendments	This Amendment ONLY
CONTRACT END DATE:	6/30/2010	
FY: 2002	$ 18,599,868.48	
FY: 2003	$ 33,079,942.80	
FY: 2004	$ 63,490,156.62	
FY: 2005	$116,014,894.00	
FY: 2006	$175,496,222.00	
FY: 2007	$175,151,878.00	
FY: 2008	$200,000,000.00	
FY: 2009	$200,000,000.00	
FY: 2010	$383,130,000.00	$17,376,600.00
Total:	$1,365,307,305.90	$17,376,600.00

Funding Certification

Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.

AMENDMENT NUMBER 21

AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 2.4.4.1.1 shall be amended by adding a new Section 2.4.4.1.1.4 "Group 5 ^{IHSDM}: Persons with Intellectual Disabilities who have been defined as the Target Population for the Integrated Health Services Delivery Model described in Section 3A of this Agreement;" and renumbering the existing Sections and eligibility Groups accordingly, including any references thereto throughout the Agreement.

2. The Select Contract shall be amended by adding a new Section 3A. For greater clarity, this new Section 3A is a separate and distinct section from Section 3.

3. The new Section 3A shall read as follows:

3A INTEGRATED HEALTH SERVICES DELIVERY MODEL FOR PERSONS WITH INTELLECTUAL DISABILITIES (i.e., Mental Retardation)

~~3A.1 General~~

3A.1.1 Notwithstanding any provision in this Agreement to the contrary, the CONTRACTOR shall be responsible for the implementation of an Integrated Health Services Delivery Model for persons with intellectual disabilities as set forth in this Section.

The model as defined herein includes the following:

3A.1.1.1 Continuous assessment of each member's physical and behavioral health needs including preventive care needs, acute and chronic physical or behavioral health conditions, and related problems specific or common to persons with Intellectual and/or Developmental Disabilities (I/DD);

3A.1.1.2 Timely access to medically necessary physical and behavioral health care services;

3A.1.1.3 Implementation of a person-centered Medical Home Model for primary care and coordination of medical information and specialized physical and behavioral health care needs by a Primary Care Physician;

3A.1.1.4 Ongoing coordination with long-term care services the member receives, including Home and Community Based Services (HCBS) provided under a Section 1915(c) waiver program for persons with intellectual disabilities (i.e., mental retardation) or Institutional services in an Intermediate Care Facility for persons with Mental Retardation (ICF/MR) or Nursing Facility (NF), as applicable; and

3A.1.1.5 Continuous collaboration between the member's care providers and payors, including TennCare, the Tennessee Department of Finance & Administration - Division of Intellectual Disabilities Services (DIDS, formerly known as DMRS), and the CONTRACTOR who will be responsible for the coordination, delivery and payment of all medically necessary covered physical and behavioral health services.

3A.1.2 The Integrated Health Services Delivery Model shall be efficient in terms of both administration and cost, shall minimize duplicative administrative functions and expenses, and shall maximize federal financial participation in both administrative and service-related expenditures for eligible service recipients.

3A.1.3 The cornerstone of the model is Nurse Care Management, which shall be provided by the CONTRACTOR as an administrative service, rather than a covered benefit. Each TennCare Select member within the target population shall have an assigned Nurse Care Manager. Nurse Care Managers shall develop an individualized, Integrated Plan of Health Care for each member, coordinate the full array of covered physical and behavioral health services eligible members need, and work closely with Independent Support Coordinators or Waiver Case Managers, as applicable and MR Waiver, ICF/MR and/or NF providers in implementing the Integrated Plan of Health Care which operates in conjunction with the member's Individual Support Plan. In addition to extensive professional nursing experience and expertise, Nurse Care Managers will receive training specific to the I/DD population, with particular focus on medical issues common in occurrence and nursing procedures frequently required for the I/DD population.

3A.2 Target Population for the Integrated Health Services Delivery Model

3A.2.1 Upon implementation of the Integrated Health Services Delivery Model for persons with intellectual disabilities and in accordance with the phased-in implementation plan set forth in this Section, the CONTRACTOR shall provide Nurse Care Management care services to all TennCare Select members with intellectual disabilities who are actively enrolled in one of the State of Tennessee's three (3) Section 1915(c) Home and Community Based Services (HCBS) waiver programs for persons with intellectual disabilities (i.e., mental retardation), including the Arlington, Statewide (or "Main") and Self-Determination Waiver Programs.

3A.2.2 Upon approval of an amendment to the State's Section 1115 TennCare Demonstration Waiver by the Centers for Medicare and Medicaid Services (CMS), the CONTRACTOR shall also provide Nurse Care Management services to all TennCare Select members with intellectual disabilities

receiving ICF/MR services in a private (i.e., non-State) Intermediate Care Facility for persons with Mental Retardation (ICF/MR), as well as TennCare Select members in the Arlington Class who are residing in public or private ICFs/MR, nursing homes or in other institutional or alternative home and community-based placements, which may include the person's (or family's) home, except that persons enrolled in the CHOICES program shall not participate in the Integrated Health Services Delivery Model.

3A.2.3 The CONTRACTOR shall provide Nurse Care Management *only* to members of the target population as defined in this Section, and subject to federal authority pursuant to an approved amendment to the State's Section 1115 TennCare Demonstration Waiver. Nurse Care Management shall not be available to persons outside the defined target population for the Integrated Health Services Delivery Model.

3A.2.4 TENNCARE will notify the CONTRACTOR regarding Arlington Class Members currently served by the Community Services Network (CSN) who elect to opt into TennCare Select and participate in the Integrated Health Services Delivery Model.

3A.2.5 For other members of the target population, TENNCARE will notify the CONTRACTOR via the 834 eligibility file when the member has been enrolled in TennCare Select, either because:

(a) s/he is in the defined target population and has elected to opt into TennCare Select; or

(b) because s/he has been auto-assigned (with an opt out provision) by virtue of being a new TennCare member who meets ICF/MR level of care eligibility and is:

(1) actively enrolled in an MR Waiver program; or

(2) upon approval by CMS of an amendment to the State's Section 1115 TennCare Demonstration Waiver, is:

(a) receiving ICF/MR services; or

(b) a member of the Arlington At-Risk Class.

Additional notification processes may be established as necessary to help facilitate timely initiation of the CONTRACTOR's care management (including assessment) activities; however, only members assigned to TennCare Select by TennCare (i.e., based on auto-assignment or an MCO change request) may participate in the Integrated Health Services Delivery Model.

3A.3 Phased-In Implementation of the Integrated Health Services Delivery Model

3A.3.1 In order to ensure a seamless transition of care for persons transitioning from CSN to the Integrated Health Services Delivery Model and to ensure the availability of resources needed to expand the model beyond Arlington Class Members, the Integrated Health Services Delivery Model shall be phased in as follows:

3A.3.2 Approximately 120 days following approval by the federal court, TennCare shall begin transitioning Arlington Class Members currently receiving services through CSN as set forth under Section 3A.19 ***Transition of Members Currently Receiving Care Through the Community Services Network.***

3A.3.3 Approximately 120 days later, TennCare shall begin expanding the model to other members of the target population, on a Grand Region by Grand Region basis, until all persons in the target population have been given an opportunity to opt into TennCare Select and participate in the

Integrated Health Services Delivery Model. At TennCare's discretion, notice and transition processes for other members of the target population may be scheduled to facilitate a more seamless transition process. TennCare shall also begin auto assigning new TennCare members in the target population to TennCare Select with the ability to opt out into a different health plan.

3A.3.4 All members of the target population assigned to TennCare Select shall be assigned to the Integrated Health Services Delivery Model.

3A.4 Nurse Care Management

3A.4.1 The CONTRACTOR shall provide Nurse Care Management in an integrated, holistic, person-centered manner.

3A.4.1.1 Nurse Care Management shall be the continuous process of:

3A.4.1.2 Assessing a member's physical and behavioral health needs;

3A.4.1.3 Identifying the covered physical and behavioral health services that are necessary to meet the member's identified needs;

3A.4.1.4 Developing and maintaining for each member an individualized, Integrated Plan of Health Care (which shall specify physical as well as behavioral health services and interventions);

3A.4.1.5 Ensuring timely access to and provision, coordination and monitoring of covered physical and behavioral health services; and

3A.4.1.6 Collaboration between providers and payors of the member's physical and behavioral health services, including physicians and other physical and behavioral health care providers, TennCare, DIDS, and the CONTRACTOR to facilitate seamless access to care and maximize health outcomes.

3A.4.2 The CONTRACTOR shall develop and implement policies and procedures for Nurse Care Management which comport with the requirements of this Section.

3A.4.2.1 Such policies and procedures shall specify the role and authority of Nurse Care Managers in authorizing needed physical and behavioral health services. At the discretion of the CONTRACTOR, authorization of home health, private duty nursing, and direct therapy services (i.e., occupational, physical and speech therapy services) may be completed by the Nurse Care Manager or through the CONTRACTOR's established UM processes but shall be coordinated by the Nurse Care Manager to ensure timely access to needed care and coordination with MR Waiver benefits.

3A.4.3 The CONTRACTOR shall ensure that, upon enrollment into the Integrated Health Services Delivery Model, MCO case management and/or disease management activities for the target population are integrated with Nurse Care Management processes and functions, and that the member's assigned Nurse Care Manager has primary responsibility for coordination of all the member's physical and behavioral health needs. The Nurse Care Manager may use resources and staff from the CONTRACTOR's case management and disease management programs, including

persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the Nurse Care Manager.

3A.4.4 The CONTRACTOR shall utilize state-of-the-art care management tools, health informatics and analytics to stratify populations, target physical and behavioral health interventions, and to identify and address gaps in care based on best practice protocols for managing specific conditions.

3A.5 Assignment of a Nurse Care Manager to Members NOT Transitioning from the Community Services Network

3A.5.1 The CONTRACTOR shall, within five (5) business days after notification of enrollment of each new member in the target population not transitioning from the Community Services Network into TennCare Select, assign a specific Nurse Care Manager who shall have primary responsibility for performance of Nurse Care Management activities as specified in this Section, and who shall be the member's point of contact for coordination of physical and behavioral health services. (Members transitioning from CSN shall have a Nurse Care Manager assigned prior to transition.)

3A.5.2 The CONTRACTOR shall, within ten (10) business days after notification of enrollment of each new member in the target population into TennCare Select, provide written notice to the member including the name and contact information for his/her assigned Nurse Care Manager, and how to obtain assistance for urgent physical and behavioral health needs after hours.

3A.5.3 The CONTRACTOR may utilize a care management support team approach to performing Nurse Care Management activities. For each participant in the Integrated Health Services Delivery model, the CONTRACTOR's Care Management Support Team shall consist of the member's Nurse Care Manager and specific other persons with relevant expertise and experience appropriate to address the needs of persons with I/DD. Care Management Support Teams shall be discrete entities within the CONTRACTOR's organizational structure dedicated to fulfilling Nurse Care Management functions. The CONTRACTOR shall establish policies and procedures which specify, at a minimum: the composition of care management support teams; the tasks that will be performed directly by the Nurse Care Manager, which shall include all assessments and face-to-face contacts; measures taken to ensure that the Nurse Care Manager remains the member's primary point of contact for physical and behavioral health needs; escalation procedures to elevate issues to the Nurse Care Manager in a timely manner; and measures taken to ensure that if a member needs to reach his/her Nurse Care Manager specifically, calls that require immediate attention by a Nurse Care Manager are handled by a Nurse Care Manager and calls that do not require immediate attention are returned by the member's Nurse Care Manager the next business day.

3A.6 Assessment of Physical and Behavioral Health Needs

3A.6.1 The CONTRACTOR shall conduct a comprehensive face-to-face assessment of each member's physical and behavioral health needs, including a comprehensive physical, behavioral, developmental, and social history; identification of all current physical or behavioral health conditions or symptoms, treatments and interventions, including currently administered prescription and over-the-counter medications; an assessment of the current status of preventive care; a thorough review of relevant physiological needs, including but not limited to gastrointestinal function, skin integrity, seizure disorders, bowel and bladder function, and nutrition and/or weight-related concerns; an assessment of any Durable Medical Equipment (DME) needs, including whether existing DME items are in good working condition and appropriate for the member's needs—both in terms of fit and functionality; and identification of key physical and behavioral health-related risks.

3A.6.1.1 For persons transitioning into the Integrated Health Services Delivery Model from the Community Services Network (CSN), such face-to-face assessment shall be completed prior to transition as set forth under Section 3A.19 ***Transition of Members Currently Receiving Care Through the Community Services Network***. For other participants in the Integrated Health Services Delivery Model assigned to TennCare Select or electing to opt into TennCare Select, such face-to-face assessment shall be as soon as possible after enrollment into TennCare Select, but must be completed in time to ensure the development of an individualized, Integrated Plan of Health Care within the timeframes set forth below.

3A.6.1.2 The schedule for the face-to-face assessment shall be coordinated with the member's guardian or conservator, as applicable, and shall be completed in the member's place of residence, except under extenuating circumstances (such as the member's hospitalization), which shall be documented in writing.

3A.6.1.3 The CONTRACTOR shall make reasonable efforts to include the member's guardian or conservator in the assessment process, and to gather relevant information from the member's guardian or conservator regarding the member's physical and/or behavioral health needs.

3A.6.2 Prior to conducting the face-to-face assessment, the CONTRACTOR shall review available data and information regarding the member's physical and behavioral health care needs and utilization, including but not limited to claims and encounter information (as applicable), Physical Status Reviews, Health Care Plans, Individual Support Plans, and other relevant data provided by DIDS and/or by CSN in order to identify health-related concerns and to help inform and guide the assessment process.

3A.7 Development of an Individualized, Integrated Plan of Health Care

3A.7.1 Upon completion of the assessment, the CONTRACTOR shall coordinate with a Care Management Support Team to develop an individualized, Integrated Plan of Health Care. Such plan shall be completed within thirty (30) calendar days of enrollment into the Integrated Health Services Delivery Model.

3A.7.2 The Care Management Support Team shall be led by the Nurse Care Manager and shall include the member and his/her family, guardian or conservator (as applicable). The Team may also

include (as appropriate), but is not limited to the member's Primary Care Physician, Independent Support Coordinator (ISC) or Waiver Case Manager (WCM), as applicable, MR Waiver providers, DIDS Advocate, physical and/or behavioral health care providers, and other VSHP staff such as the physical or behavioral health Medical Director(s), Social Worker, etc.

3A.7.3 Nurse Care Managers shall consult with the member's PCP, specialists, behavioral health providers, other providers, and interdisciplinary team experts, as needed when developing the Integrated Plan of Health Care.

3A.7.4 The Integrated Plan of Health Care shall include, at a minimum:

3A.7.4.1 Pertinent demographic information regarding the member including the name and contact information of the guardian or conservator and a list of other persons authorized by the member to have access to health care related information and to assist with assessment, planning, and/or implementation of health care related services and supports;

3A.7.4.2 Description of any special communication needs including interpreters or special devices;

3A.7.4.3 The Primary Care Physician and his/her contact information;

3A.7.4.4 A summary of key information from the assessment, including relevant physical, behavioral, developmental, and/or social history; current physical or behavioral health conditions or symptoms, treatments and interventions; the current status of preventive care; and relevant physiological and DME needs;

3A.7.4.5 Health (including mental health)-related goals, objectives and desired health, functional, and quality of life outcomes for the member;

3A.7.4.6 A description of the member's physical and behavioral health needs, including a description of medical equipment used or needed by the member (if applicable);

3A.7.4.7 Physical or behavioral health risks and appropriate interventions and strategies to mitigate those risks;

3A.7.4.8 Any steps caregivers should take in the event of an emergency that differ from the standard emergency protocol;

3A.7.4.9 The physical and behavioral health services and interventions that are necessary to meet the member's identified needs;

3A.7.4.10 Health care tasks and functions that will be performed by family members and other caregivers, such as routine administration of medications;

3A.7.4.11 A detailed listing of the physical and behavioral health services the member will receive from other payor sources including the payor of such services (e.g., Medicare home health);

3A.7.4.12 A detailed listing of covered physical and behavioral health services to be provided by the CONTRACTOR, including preventive services;

3A.7.4.13 When home health and/or private duty nursing services will be authorized by the CONTRACTOR, a detailed and adequate back-up plan for situations when regularly scheduled HH/PDN providers are unavailable or do not arrive as scheduled (the back-up plan may include paid and unpaid supports and shall include the names and telephone numbers of persons and agencies to contact and the services provided by listed contacts); and

3A.7.4.14 Frequency of planned Nurse Care Management contacts needed, which shall include consideration of the member's individualized needs and circumstances, and which shall at minimum meet required contacts as specified in this Section (unplanned Care Manager contacts shall be provided as needed).

3A.7.5 During the development of the member's Integrated Plan of Health Care, the Nurse Care Manager shall educate the member and his/her guardian or conservator, as applicable regarding end of life care and his/her ability to use advance directives and shall document the member's decision in the member's Integrated Plan of Health Care.

3A.7.6 For persons residing in Institutional Placements, the Integrated Plan of Health Care shall supplement the facility's plan of care (which is required pursuant to federal regulation), and shall focus on the provision of services covered by TennCare Select that are beyond the scope of the Institutional ICF/MR or NF benefit, including targeted strategies related to improving health, functional, or quality of life outcomes (e.g., related to disease management or pharmacy management) or to increasing and/or maintaining health and/or functional status, as appropriate.

3A.7.7 The member's Nurse Care Manager shall participate as appropriate in the Institutional facility's care planning process and advocate for the member regarding physical and behavioral health needs.

3A.7.8 The member's Nurse Care Manager shall ensure that the member (and/or his/her guardian or conservator, as appropriate) reviews, signs and dates the Integrated Plan of Health Care as well as any updates.

3A.7.9 The CONTRACTOR shall develop policies and procedures that describe the measures taken by the CONTRACTOR to address instances when a member (or his/her guardian or conservator, as appropriate) refuses to sign the plan of care. The policies and procedures shall include a specific escalation process (ultimately to TENNCARE) that includes a review of the reasons for the refusal as well as actions taken to resolve any disagreements with the Integrated Plan of Health Care.

3A.7.10 The member's Nurse Care Manager shall provide a copy of the member's completed Integrated Plan of Health Care, including any updates, to the member, the member's guardian or conservator, as applicable, the MR Waiver ISC or Case Manager, and the member's community residential alternative provider, as applicable. The member's Nurse Care Manager/Care Management Support Team shall provide copies to other providers authorized to deliver care to the member upon request, and shall ensure that such physical and behavioral health care providers who do not receive a copy of the Integrated Plan of Health Care are informed in writing of all relevant information needed to ensure the provision of quality physical and behavioral health services for the member.

3A.7.11 The CONTRACTOR shall immediately begin to address all urgent physical and behavioral health care needs, and shall not wait for completion of the Integrated Plan of Health Care to arrange urgently needed care.

3A.7.12 If the CONTRACTOR is unable to initiate in a timely manner any covered physical or behavioral health service needed by the member that is within the scope of benefits available under the TennCare 1115 Waiver program, the CONTRACTOR shall, pursuant to established *Grier* notice requirements and templates, issue written notice to the member, documenting the service(s) that will be delayed, the reasons for the delay, and the date the service(s) will start, and shall make good faith efforts to ensure that services are provided as soon as practical.

3A.7.13 The CONTRACTOR shall provide to TennCare a monthly report of all delays in service notices issued to participants in the Integrated Health Services Delivery Model, which shall specify at a minimum, the member's name and Medicaid ID, the type of service delayed, the date the service was authorized, the date the notice of delay was issued, the reason for the delay, and the projected date that the service will be available.

3A.7.14 Nurse Care Managers shall 1) timely communicate to Arlington Class members' Independent Support Coordinator and/or Advocate, as applicable, all TennCare Select denials of service which trigger due process appeal rights pursuant to the *Grier* Revised Consent Decree; and 2) provide a copy of the notice of action.

3A.8 Reassessments of Need and Updates to the Integrated Plan of Health Care

3A.8.1 The Nurse Care Manager shall reassess physical and behavioral health needs at least annually and within ten (10) business days of the CONTRACTOR's becoming aware that the member's functional, physical, or behavioral status has changed significantly which may include, but is not limited to:

3A.8.1.1 An acute hospital admission or Emergency Department utilization;

3A.8.1.2 A newly diagnosed physical or behavioral health condition;

3A.8.1.3 A significant change in an existing physical or behavioral health condition;

3A.8.1.4 A significant decline in functional status, such as loss of mobility; or

3A.8.1.5 Behavioral destabilization, including new or increased self-injurious behaviors, property destruction, etc.

3A.8.2 The Nurse Care Manager shall update the Integrated Plan of Health Care as needed to reflect significant changes in condition, treatments or interventions; physical and behavioral health needs, risks and interventions; physical and behavioral health services, etc.

3A.9 Assignment of a Primary Care Physician and Establishment of a Medical Home

3A.9.1 Upon enrollment into TennCare Select, each participant in the Integrated Health Services Delivery Model shall be assigned a Primary Care Physician (PCP), including members dually eligible for TennCare and Medicare.

3A.9.1.1 Assignment of the PCP shall, to the maximum extent possible and appropriate, be consistent with the member's current utilization of primary care services, if applicable, so long as such PCP participates in the TennCare Select network.

3A.9.1.2 To the extent that (1) a newly enrolled member wishes to utilize a different PCP; (2) a member is not utilizing primary care services upon enrollment into TennCare Select; or (3) a member's current PCP elects not to participate in the TennCare Select network, the member's Nurse Care Manager shall coordinate with the member and his/her guardian or conservator to select a participating PCP who will be assigned to the member.

3A.9.1.3 The PCP shall be responsible for continuous comprehensive primary care and coordination of medical information and specialized physical and behavioral health care services, including specialty referrals.

3A.9.2 The Nurse Care Manager shall coordinate with the PCP to provide information, address needs and concerns, ensure timely access to needed specialty care, and to facilitate a comprehensive, holistic, person-centered approach to care, and shall provide assistance as needed in scheduling needed appointments, and in arranging non-emergency transportation services.

3A.9.3 The CONTRACTOR shall be responsible for helping to facilitate access to and utilization of appropriate preventive care services, which shall include maintenance of an internal tracking system which identifies preventive care status and pending preventive care due dates for each participant in the Integrated Health Services Delivery Model, and screening services provided in accordance with nationally accepted standards or guidelines develop or endorsed by respected medical organizations such as the Centers for Disease Control and Prevention, including but not limited to pap smears, mammograms, prostate cancer screenings, and colorectal cancer screenings, as applicable. Nurse Care Managers shall utilize such tracking system to facilitate timely access to needed care, which may include as needed assistance in scheduling needed appointments, and in arranging non-emergency medical transportation services.

3A.9.4 The CONTRACTOR shall monitor utilization of Emergency Department services in an effort to identify physical or behavioral health care needs, ensure appropriate utilization of Primary and/or Specialty Care, improve continuity of care, and to help establish the medical home.

3A.10 Transitions of Care

3A.10.1 Nurse Care Managers shall have an integral role in all care transitions, including discharge from an inpatient acute or psychiatric hospital setting, transition from an Institutional to HCBS setting, transitions between Institutional settings, and transitions between community residential providers. The Nurse Care Manager shall work with the discharge planner, ISC or Waiver Case Manager (as applicable), and guardian or conservator (as applicable) to determine the physical and/or behavioral health services that will be needed upon discharge or transition (as applicable), and to ensure that such services are arranged and provided in a timely manner.

3A.10.2 For members receiving home health, private duty nursing, or occupational, physical or speech therapy services upon transition, the Nurse Care Manager shall monitor to ensure that such services are implemented timely and in accordance with the Integrated Plan of Health Care.

3A.10.3 Upon implementation of the Electronic Visit Verification (EVV) system in the CHOICES in Long-Term Care Program, such monitoring shall include using the EVV system to monitor the

initiation and daily provision of services in accordance with the member's Integrated Plan of Health Care, and immediate action to resolve any service gaps.

3A.11 Monitoring Provision of Physical and Behavioral Health Services

3A.11.1 Upon the scheduled initiation of physical or behavioral health services identified in the Integrated Plan of Health Care, the member's Nurse Care Manager/Care Management Support Team shall begin monitoring to ensure that services have been initiated and continue to be provided as authorized.

3A.11.2 Upon implementation of the Electronic Visit Verification system as required for the CHOICES program, such monitoring shall include ongoing monitoring via electronic visit verification to ensure that services entered into the EVV, i.e., home health services, private duty nursing, and occupational, physical and speech therapy services covered under the TennCare 1115 Waiver program, are provided in accordance with the member's Integrated Plan of Health Care, including the amount, frequency, duration and scope of each service, in accordance with the member's service schedule; and that services continue to meet the member's needs.

3A.11.3 The Nurse Care Manager shall identify and immediately address service gaps, ensure that back-up plans are implemented and effectively working, and evaluate service gaps to determine their cause and to minimize gaps going forward. The CONTRACTOR shall describe in policies and procedures the process for identifying, responding to, and resolving service gaps in a timely manner.

3A.11.4 The Nurse Care Manager shall provide assistance in resolving concerns about service delivery or providers, including the quality of care rendered by providers or Nurse Care Management staff.

3A.12 Other Ongoing Nurse Care Management Responsibilities

3A.12.1 The CONTRACTOR shall provide to contract providers, including but not limited to physicians and behavioral health providers, and caregivers information regarding the role of the Nurse Care Manager and shall request that providers and caregivers notify a member's Nurse Care Manager, as expeditiously as warranted by the member's circumstances, of any significant changes in the member's condition or care, hospitalizations, or recommendations regarding physical or behavioral health services that may be needed.

3A.12.2 The CONTRACTOR shall have systems in place to facilitate timely communication between internal departments and the Nurse Care Manager to ensure that each Nurse Care Manager receives all relevant information regarding his/her members, e.g., member services, disease management, utilization management, and claims processing. The Nurse Care Manager shall follow-up on this information as appropriate, e.g., documentation in the member's plan of care, monitoring of outcomes, and, as appropriate, needs reassessment and updating the plan of care.

3A.12.3 The CONTRACTOR shall monitor and evaluate a member's Emergency Department and behavioral health crisis service utilization to determine the reason for these visits. The Nurse Care Manager shall take appropriate action to facilitate appropriate utilization of these services, e.g., communicating with the member's providers, educating the member, conducting a needs reassessment, and/or updating the member's Integrated Plan of Health Care and to better manage the member's physical health or behavioral health condition(s).

3A.12.4 The CONTRACTOR shall develop policies and procedures to ensure that Nurse Care Managers are actively involved in discharge planning when a member is hospitalized. The CONTRACTOR shall define circumstances that require that hospitalized members receive a face-to-face visit to complete a needs reassessment and an update to the member's Integrated Plan of Health Care as needed.

3A.12.5 The Nurse Care Manager/Care Management Support Team shall coordinate with Medicare payers, Medicare Advantage plans, and Medicare providers as appropriate to coordinate the care and benefits of members who are also eligible for Medicare. In accordance with the State's Coordination of Benefits Agreement with the Centers for Medicare and Medicaid Services (CMS), TENNCARE shall establish a process for sharing Medicare Parts A and B claims data with the CONTRACTOR in order to facilitate a more complete picture of health care services provided to dual eligible members, and to further improve coordination and quality of care for members.

3A.13 Minimum Nurse Care Manager Contacts

3A.13.1 The Nurse Care Manager shall conduct all needs assessment and care planning activities, and shall make all minimum care management contacts in the member's place of residence, except under extenuating circumstances (such as assessment and care planning conducted during the member's hospitalization, or upon the member's request), which shall be documented in writing.

3A.13.2 The CONTRACTOR shall ensure that Nurse Care Managers assess each member's need for contact with the Nurse Care Manager to ensure that the member's physical and behavioral health needs are met.

3A.13.3 At a minimum, members participating in the Integrated Health Services Delivery Model with complex unstable physical or behavioral health needs shall be visited in their residence face-to-face by their Nurse Care Manager at least monthly.

3A.13.4 At a minimum, members participating in the Integrated Health Services Delivery Model with complex stable physical or behavioral health needs shall be contacted by their Nurse Care Manager at least monthly either in person or by telephone, and shall be visited in their residence face-to-face by their Nurse Care Manager at least quarterly.

3A.13.5 At a minimum, members participating in the Integrated Health Services Delivery Model with no complex physical or behavioral health needs shall be contacted by their Nurse Care Manager at least quarterly either in person or by telephone, and shall be visited in their residence face-to-face by their Nurse Care Manager at least semi-annually.

3A.13.6 The CONTRACTOR shall ensure that at each face-to-face visit the Nurse Care Manager makes the following observations and documents the observations in the member's file:

3A.13.6.1 Member's physical condition including observations of the member's skin, weight changes and any visible signs or symptoms of physical illness;

3A.13.6.2 Member's mood and emotional well-being;

3A.13.6.3 Member's satisfaction with physical and behavioral health services;

3A.13.6.4 A statement by the member regarding any physical or behavioral health concerns or questions;

3A.13.6.5 A statement from the member's guardian and/or conservator regarding any concerns or questions (when the guardian/conservator is available); and

3A.13.6.6 Member's upcoming physical and behavioral health appointments.

3A.14 Nurse Care Management Staff

3A.14.1 At a minimum, Nurse Care Managers for Arlington class members in the Integrated Health Services Delivery Model shall be a Registered Nurse with at least three (3) years professional nursing experience and a minimum of two (2) years experience providing care management (preferably in a managed care setting). The CONTRACTOR shall use best efforts to employ Nurse Care Managers with appropriate certifications including Certified Case Manager (CCM) and Developmental Disabilities (DD) Certification. Nurse Care Managers who meet established qualifications but are not certified upon employment shall be required to take the certification exam(s) upon obtaining the required minimum experience.

3A.14.1.1 The CONTRACTOR shall use its best efforts to recruit and employ nurse case managers employed by CSN who pass the background checks and meet the contractual educational and experiential requirements for Nurse Care Managers for Arlington Class members participating in the IHSD model.

3A.14.2 At a minimum, Nurse Care Managers for other participants in the Integrated Health Services Delivery Model shall be a Registered or Licensed nurse with at least (2) years professional nursing experience. Nurse Care Managers with less than three (3) years professional nursing experience and/or less than two (2) years providing care management, and all Licensed (but not Registered) Nurses shall have a Registered Nurse Supervisor who meets minimum qualifications for Nurse Care Management for Arlington class members. All Nurse Care Managers who meet established qualifications but are not CCM and DD certified upon employment shall be encouraged to complete such certification(s) upon obtaining the required minimum experience.

3A.14.3 The CONTRACTOR shall ensure an adequate number of Nurse Care Managers are available and that sufficient staffing ratios are maintained to address the needs of participants in the Integrated Health Services Delivery Model and to meet all requirements described in this Section.

3A.14.4 For Arlington class members transitioning into the Integrated Health Services Delivery Model from CSN, the Nurse Care Manager-to-member ratio shall not exceed 1:15 for any member during the pre-implementation and first ninety (90) days post-implementation phase. Once assessments have been completed and all CSN members are successfully transitioned into the Integrated Health Services Delivery Model, information regarding members gathered through assessment UM, and other processes as well as predictive modeling may be utilized to help identify members with the most significant health and/or behavioral health needs who are at the highest risk and who offer the greatest potential for improvements in health outcomes, and to stratify members and prioritize Nurse Care Manager resources accordingly, such that individual Nurse Care Managers may have a greater or lesser number of assigned members based on the level of need of such members. For a period of two (2) years following implementation of the Integrated Health Services Delivery Model, the average Nurse Care Manager-to-member ratio shall not exceed 1:35 for Arlington class members who are not in an ICF/MR or other institutional placement.

3A.14.5 Similar processes shall be used for identification, stratification, and prioritization of other participants in the Integrated Health Services Delivery Model, with more intensive staffing during the post-enrollment phase, after which time individual Nurse Care Managers may have a greater or lesser number of assigned members based on the level of need of such members.

3A.14.6 The CONTRACTOR shall monitor staffing ratios and adjust ratios as necessary to ensure that Nurse Care Managers are able to meet the requirements of this Section and address members' needs.

3A.14.7 The CONTRACTOR shall provide, at least sixty (60) days prior to implementation of the Integrated Health Services Delivery Model, a Nurse Care Management Staffing Plan, which shall specify the number of Nurse Care Managers, Nurse Care Manager Supervisors, other supporting Care Management Support Team members the CONTRACTOR plans to initially employ. TENNCARE shall notify the CONTRACTOR in writing if the Nurse Care Management Staffing Plan is insufficient and may require modifications to ensure, prior to implementation of the Integrated Health Services Delivery Model, that the CONTRACTOR has sufficient Nurse Care Management staff. After the Integrated Health Services Delivery Model has been implemented, the CONTRACTOR shall notify TENNCARE in writing of substantive changes to its Nurse Care Management Staffing Plan, including a variance of twenty (20) percent or more from the Staffing Plan. TENNCARE may request changes in the CONTRACTOR's Nurse Care Management Staffing Plan at any time it determines that the CONTRACTOR does not have sufficient Nurse Care Management staff to properly and timely perform its obligations under this Agreement.

3A.14.8 The CONTRACTOR shall establish a system to assign Nurse Care Managers and to notify the member of his/her assigned Nurse Care Manager's name and contact information.

3A.14.9 Nurse Care Managers shall be physically located within each Grand Region of the State to ensure proximity to the member and care providers.

3A.14.10 The CONTRACTOR shall ensure that members have a dedicated toll-free telephone number to contact regarding physical or behavioral health services, which shall be staffed by dedicated customer service representatives. The CONTRACTOR shall facilitate transfer (without having to disconnect or place a second call) to a member's Nurse Care Manager or a member of their Care Management Support Team (if applicable) during normal business hours. If the member's Nurse Care Manager or a member of the member's Care Management Support Team is not available, the call shall be answered by another qualified staff person in the Nurse Care Management unit. The CONTRACTOR shall also ensure access to after-hours assistance for members with urgent physical or behavioral health questions or concerns.

3A.14.11 The CONTRACTOR shall permit members to change to a different Nurse Care Manager if the member desires and there is an alternative Nurse Care Manager available. Such availability may take into consideration the CONTRACTOR's need to efficiently deliver Nurse Care Management in accordance with requirements specified herein, including for example, the assignment of a Nurse Care Managers based on the geographic area in which members reside.

3A.14.12 In order to ensure quality and continuity of care, the CONTRACTOR shall make efforts to minimize the number of changes in the Nurse Care Manager assigned to a member. Circumstances in which a CONTRACTOR-initiated change in Nurse Care Managers may be appropriate include, but are not limited to, the following:

3A.14.12.1 The Nurse Care Manager is no longer employed by the CONTRACTOR;

3A.14.12.2 The Nurse Care Manager has a conflict of interest and cannot serve the member;

3A.14.12.3 The Nurse Care Manager is on temporary leave from employment; and

3A.14.12.4 Nurse Care Manager caseloads must be adjusted due to the size or intensity of an individual Nurse Care Manager's caseload.

3A.14.13 The CONTRACTOR shall develop policies and procedures regarding notice to members of Nurse Care Manager changes initiated by either the CONTRACTOR or the member, including advance notice of planned Nurse Care Manager changes initiated by the CONTRACTOR.

3A.14.14 The CONTRACTOR shall ensure continuity of care when Nurse Care Manager changes are made whether initiated by the member or by the CONTRACTOR. The CONTRACTOR shall demonstrate use of best practices by encouraging newly assigned Nurse Care Managers to attend a face-to-face transition visit with the member and the out-going Nurse Care Manager when possible.

3A.15 Nurse Care Manager Training

3A.15.1 The CONTRACTOR shall provide competency-based initial training to newly hired Nurse Care Managers and competency-based ongoing training at least annually to all Nurse Care Managers and Supervisors. Initial training topics shall include at a minimum:

3A.15.1.1 The Integrated Health Services Delivery Model;

3A.15.1.2 Covered benefits for TennCare Select members;

3A.15.1.3 Section 1915(c) Waiver Programs for Persons with Intellectual Disabilities (i.e., Mental Retardation), including covered benefits and Independent Support Coordination or Case Management, as applicable;

3A.15.1.4 Medicare benefits for dual eligible (i.e., Medicare/Medicaid) members;

3A.15.1.5 Coordination of care among programs, payors and providers;

3A.15.1.6 The Medical Home;

3A.15.1.7 Conducting a comprehensive assessment of physical and behavioral health needs, and development and implementation of an Integrated Plan of Health Care;

3A.15.1.8 Development and implementation of back-up plans for home health and private duty nursing services;

3A.15.1.9 Use of the Electronic Visit Verification system for persons receiving home health, private duty nursing, and/or occupational, physical or speech therapy services (upon implementation of such system in the CHOICES program);

3A.15.1.10 How to immediately identify and address service gaps;

3A.15.1.11 Conducting a home visit and use of the monitoring checklist;

3A.15.1.12 Management of critical transitions (including hospital discharge planning);

3A.15.1.13 Intellectual disabilities;

3A.15.1.14 Physical disabilities;

3A.15.1.15 Physical and behavioral health issues common in occurrence and nursing procedures frequently required for persons with intellectual disabilities;

3A.15.1.16 Disease management;

3A.15.1.17 Identification and management of behavioral health conditions;

3A.15.1.18 Evaluation and management of physical and behavioral health risks;

3A.15.1.19 Advance directives and end of life care;

3A.15.1.20 HIPAA;

3A.15.1.21 Cultural competency; and

3A.15.1.22 Disaster planning.

3A.15.2 The CONTRACTOR shall establish roles and job responsibilities for Nurse Care Managers. The job responsibilities shall include a description of activities and required timeframes for completion. These activities shall include the requirements specified in this Section.

3A.16 Nurse Care Management Monitoring

3A.16.1 The CONTRACTOR shall develop a comprehensive program for monitoring, on an ongoing basis, the effectiveness of its Nurse Care Management processes. The CONTRACTOR shall immediately remediate all individual findings identified through its monitoring process, and shall also track and trend such findings and remediations to identify systemic issues of poor performance and/or non-compliance, implement strategies to improve care coordination processes and resolve areas of non-compliance, and shall measure the success of such strategies in addressing identified issues. At a minimum, the CONTRACTOR shall ensure that:

3A.16.1.1 Needs assessments and reassessment, as applicable, occur on schedule and identify members' physical and behavioral health needs;

3A.16.1.2 Integrated Plans of Health Care are developed and updated on schedule and in compliance with this Agreement;

3A.16.1.3 Integrated Plans of Health Care reflect physical and behavioral health needs identified in the assessment and reassessment processes;

3A.16.1.4 Integrated Plans of Health Care are appropriate and adequate to address members' physical and behavioral health needs;

3A.16.1.5 Services are delivered as specified in the Integrated Plan of Health Care and authorized by the CONTRACTOR;

3A.16.1.6 Services are delivered in a timely manner;

3A.16.1.7 Service utilization is appropriate;

3A.16.1.8 Service gaps are identified and addressed in a timely manner;

3A.16.1.9 Minimum Nurse Care Manager contacts are conducted;

3A.16.1.10 Nurse Care Manager-to-member ratios are appropriate.

3A.16.2 The CONTRACTOR shall conduct periodic consumer satisfaction surveys of TennCare Select Members in the Arlington Class who are participating in the IHSD model, and shall provide such results to TennCare for review and dissemination.

3A.17 Use of an Electronic Visit Verification System

3A.17.1 Upon the development and implementation of an Electronic Visit Verification (EVV) system under the CHOICES in Long-Term Care Program, the CONTRACTOR shall utilize such system to monitor member receipt and utilization of medically necessary home health, private duty nursing and occupational, physical and speech therapy services covered under the TennCare 1115 Waiver program that are authorized by the CONTRACTOR. The EVV system shall have the following minimal functionality:

3A.17.1.1 The ability to log the arrival and departure of individual provider staff person;

3A.17.1.2 The ability to verify in accordance with business rules that services are being delivered in the correct location (e.g., the member's residence);

3A.17.1.3 The ability to verify the identity of the individual provider staff person providing the service to the member;

3A.17.1.4 The ability to match services provided to a member with services authorized in the Integrated Plan of Health Care;

3A.17.1.5 The ability to ensure that the provider delivering the service is authorized to deliver such services;

3A.17.1.6 The ability to establish a schedule of services for each member which identifies the time at which each service is needed, and the amount, frequency, duration and scope of each service, and to ensure adherence to the established schedule;

3A.17.1.7 The ability to provide immediate (i.e., "real time") notification to Nurse Care Managers if a provider does not arrive as scheduled or otherwise deviates from the authorized schedule so that service gaps and the reason the service was not provided as scheduled, are immediately identified and addressed, including through the implementation of back-up plans, as appropriate;

3A.17.1.8 The ability for the provider to submit claims to the CONTRACTOR; and

3A.17.1.9 The ability to reconcile paid claims with service authorizations.

3A.17.2 The CONTRACTOR shall monitor and use information from the EVV system to verify that home health, private duty nursing, and occupational, physical and speech therapy services covered under the TennCare 1115 Waiver program are provided as specified in the Integrated Plan of Health Care, and in accordance with the established schedule, including the amount, frequency, duration, and scope of each service, and that services are provided by the authorized provider; and to identify and immediately address service gaps, including late and missed visits. The CONTRACTOR shall monitor services anytime a member is receiving services, including after the CONTRACTOR's regular business hours.

3A.18 Care Management System

3A.18.1 The CONTRACTOR shall develop and maintain an electronic care management system that includes the functionality to ensure compliance with all requirements specified in this Agreement, and in TennCare policies and protocols, including but not limited to the following:

3A.18.1.1 The ability to capture and track key dates and timeframes specified in this Agreement, e.g., as applicable, date of enrollment into TennCare Select and the Integrated Health Services Delivery Model, date of Nurse Care Manager assignment and notification to the member, date of the face-to-face assessment; date of completion of the individualized, Integrated Plan of Health Care; date of authorization and initiation of services specified in the Integrated Plan of Health Care, date of each reassessment, and the date of each update to the Integrated Plan of Health Care;

3A.18.1.2 The ability to capture and track compliance with minimum Nurse Care Manager contacts as specified in this Agreement;

3A.18.1.3 The ability to track and notify the Nurse Care Manager regarding key dates, e.g., date for minimum Nurse Care Manager contacts; date for annual reassessment of needs reassessment;

3A.18.1.4 The ability to capture and track needs assessments and reassessments;

3A.18.1.5 The ability to capture and monitor the Integrated Plan of Health Care;

3A.18.1.6 The ability to track requested and approved service authorizations, including any services provided as a cost-effective alternative to other covered services;

3A.18.1.7 The ability to establish a schedule of home health, private duty nursing and/or occupational, physical or speech therapy services for each member which identifies the time at which each service is needed and the amount, frequency, duration and scope of each service;

3A.18.1.8 The ability to provide, via electronic interface with the EVV system, service authorizations on behalf of the member, including the schedule at which each service is needed;

3A.18.1.9 The ability to track service delivery against authorized services and providers;

3A.18.1.10 The ability to track actions taken by the Nurse Care Manager to immediately address service gaps; and

3A.18.1.11 The ability to document case notes relevant to the provision of care coordination.

3A.19 Transition of Members Currently Receiving Care Through the Community Services Network

3A.19.1 Upon the determination of a schedule for implementation of the Integrated Health Services Delivery Model, TennCare will issue notice to Arlington Class Members currently receiving care through the CSN. The notice shall be sent to the member, and the family or conservator.

3A.19.2 Such notice shall provide sixty (60) days advance notice of the termination of CSN's contracted role in coordinating and managing care for Arlington Class Members. Members will be given thirty (30) days to notify TennCare if they wish to transition from Community Services Network into TennCare Select and to participate in the Integrated Health Services Delivery Model. A form will be enclosed that may be used to provide such notification.

3A.19.3 Upon receipt of notification from a member or the family or conservator, TennCare shall notify the CONTRACTOR of the names, family or conservator names and contact information (as appropriate), and the current residence of Arlington Class Members electing to opt into TennCare Select and to participate in the Integrated Health Services Delivery Model. Such notification shall include the name and contact information for the currently assigned CSN Nurse Care Manager (if made available by CSN), and the name and contact information for the current Independent Support Coordinator or Case Manager (as applicable)—which shall be provided by DIDS. A notification process shall be established with the CONTRACTOR prior to implementation.

3A.19.4 The CONTRACTOR shall, within five (5) business days of such notification by TENNCARE, assign a specific Nurse Care Manager who shall have primary responsibility for performance of Nurse Care Management activities as specified in this Agreement, and who shall be the member's point of contact for coordination of physical and behavioral health services.

3A.19.5 The CONTRACTOR shall, within ten (10) business days of such notification by TENNCARE, provide written notice to the member including the name, phone number, business addresses and email address for his/her assigned Nurse Care Manager, and how to obtain assistance for urgent physical and behavioral health needs after hours. Such notice may be hand-delivered during the first face-to-face visit, if completed within (10) business days.

3A.19.6 The Nurse Care Manager shall contact the currently assigned CSN Nurse Care Manager (if available) and the Independent Support Coordinator or Waiver Case Manager (as applicable) to obtain a copy of the current Individual Support Plan, and to identify current medical, behavioral and long-term care (including HCBS) services the member is receiving, as well as providers of such services.

3A.19.7 The Nurse Care Manager shall request and review available medical records, and shall contact existing physical and behavioral health and long-term care providers as needed to help guide and inform the assessment and transition processes.

3A.19.8 As part of the transition process, the assigned Nurse Care Manager shall utilize such contacts and medical information to help identify members currently receiving barbiturates and benzodiazepines through CSN. (The State shall also seek to obtain such information directly from CSN.) If a member is currently receiving barbiturates and benzodiazepines through CSN, the Nurse Care Manager shall contact the prescribing physician to help facilitate transition to covered medications prior to the member's transition to the Integrated Health Services Delivery Model.

3A.19.9 Also as part of the transition process, the assigned Nurse Care Manage shall utilize such contacts and medical information to identify any service that an Arlington Class member was receiving through CSN that is not a covered benefit under either TennCare Select or the Arlington waiver and when appropriate, will work with the MCO or the waiver to attempt to transition such Class member to an appropriate covered service. The CONTRACTOR shall provide to TennCare for review and dissemination quarterly reports on such non-covered services beginning one quarter after CSN members begin transitioning from CSN to the IHSD model and continuing for one year after all Arlington Class members have been transitioned from CSN.

3A.19.10 The Nurse Care Manager shall schedule a face-to-face visit with the member and family or conservator to provide an introduction to the Integrated Health Services Delivery Model and to complete the face-to-face assessment.

3A.19.11 For members transitioning from CSN to the Integrated Health Services Delivery Model, the CONTRACTOR shall include in the Integrated Plan of Health Care identification of all transition of care issues and concerns, including specific actions that will be taken to address such issues and concerns, and to ensure a seamless transition of care.

3A.19.12 Upon transition to the Integrated Health Services Delivery Model, the CONTRACTOR shall continue providing all covered physical and behavioral health services in accordance with the plan of care in place authorized by CSN for a period of at least thirty (30) calendar days, without regard to whether such services are being provided by contract or non-contract providers. Reimbursement for such services shall be provided in accordance with established in-network rates. Such period shall be extended as necessary to ensure seamless transition to the newly developed Integrated Plan of Health Care.

3A.19.13 Members not electing to transition to TennCare Select will remain enrolled with their current MCO and will begin receiving covered physical and behavioral health services through their assigned MCO. Nurse Care Management shall be available only to Arlington Class Members opting to enroll in TennCare Select.

3A.20 Coordination with Long-Term Care Services

3A.20.1 The CONTRACTOR shall provide ongoing coordination with long-term care services the member receives, including Home and Community Based Services (HCBS) provided under a Section 1915(c) waiver program for persons with intellectual disabilities (i.e., mental retardation) or Institutional services in an Intermediate Care Facility for persons with Mental Retardation (ICF/MR) or Nursing Facility, as applicable; and continuous collaboration between the member's care providers and payors, including TennCare, DIDS, and the CONTRACTOR who will be responsible for the coordination, delivery and payment of all medically necessary covered physical and behavioral health services.

3A.20.2 Each member's Nurse Care Manager shall participate in the Individual Support Plan development process as needed to ensure the identification of physical and/or behavioral health needs and to facilitate timely access to covered physical and/or behavioral health services.

3A.20.3 The Nurse Care Manager shall be the single point of contact for coordinating the member's physical and behavioral health needs, even when such care may be provided as an Extended State Plan benefit under one of the State's Section 1915(c) Waiver programs for persons with intellectual disabilities (i.e., mental retardation).

3A.20.4 TennCare and DIDS shall provide training for Nurse Care Managers regarding covered HCBS Waiver benefits, including specific delineation of services covered under the TennCare 1115 Waiver (i.e., Medicaid State Plan), and services covered under the MR Waiver programs. If a service needed by an MR Waiver participant is not covered under the TennCare 1115 Waiver Program, but is instead covered under the MR Waiver program in which the member is enrolled, the Nurse Care Manager shall be responsible for coordinating with the Independent Support Coordinator (ISC) or Waiver Case Manager (WCM), as applicable, to address the member's need. Such responsibility shall not be satisfactorily met by means of redirecting the member or guardian/conservator to the ISC or WCM, or even by referral to the ISC or WCM. The Nurse Care Manager shall coordinate with the ISC or WCM to ensure that the physical or behavioral health need is timely addressed.

3A.21 TennCare Select Provider Network

3A.21.1 The CONTRACTOR shall utilize the TennCare Select provider network to deliver services to participants in the Integrated Health Services Delivery Model.

3A.21.2 The CONTRACTOR shall recruit and contract with an adequate number of providers to meet the needs of all TennCare Select Members (as set forth in this Agreement), including participants in the Integrated Health Services Delivery Model.

3A.21.3 The CONTRACTOR's network must have adequate capacity to deliver covered physical and behavioral health services that meet the needs of persons with I/DD. Indicators of an adequate network include, but are not limited to:

3A.21.3.1 The CONTRACTOR meets guidelines established in this Agreement for a provider network.

3A.21.3.2 The CONTRACTOR has sufficient types and numbers of providers to be able to consistently deliver services in a timely manner; and

3A.21.3.3 The CONTRACTOR has within its network specialized health providers with sufficient expertise to deliver covered physical and behavioral health needed by persons with I/DD.

3A.21.4 The CONTRACTOR shall, within the TennCare Select network, identify and/or recruit and contract with physical and behavioral health care providers, in particular PCPs, who have the qualifications, capabilities and resources to work with persons with I/DD.

3A.21.5. Such PCPs shall be identified as providers in a special primary care network for TennCare Select members in the Integrated Health Services Delivery Model that is modeled on the TennCare Select BPN network for children in state custody; however, members of the Integrated Health

Services Delivery Model shall be permitted to utilize TennCare Select Network providers outside the special primary care network.

3A.21.6 The CONTRACTOR shall make its best efforts to recruit and include in the TennCare Select Network of service providers, the active CSN PCPs and the active CSN specialty service providers (i.e., providers that have delivered covered services to CSN members within the last twelve (12) months), provided that such providers satisfy credentialing requirements. The CONTRACTOR shall provide to TennCare for review and dissemination quarterly reports on its efforts to recruit CSN providers beginning one quarter after approval of the federal court to replace CSN with the IHSD model, and continuing for one year after all Arlington Class members have been transitioned from CSN.

3A.21.7 The CONTRACTOR is permitted to offer PCPs an additional per member per month fee if necessary to recruit the requisite number of providers and cause them to undertake the responsibilities associated with caring for members of the Integrated Health Services Delivery Model. These responsibilities will be reflected in the provider agreement between the CONTRACTOR and any PCP who is offered and accepts the additional per member per month fee.

3A.21.8 The CONTRACTOR shall develop policies and procedures for assigning participants in the Integrated Health Services Delivery Model to PCPs with I/DD expertise.

3A.21.9 The CONTRACTOR shall implement, distribute and train and monitor PCPs and specialists regarding the use of best practice guidelines for acute and chronic conditions common to persons with I/DD.

3A.21.10 The CONTRACTOR shall provide training opportunities for PCPs and other providers regarding the unique needs of persons with I/DD, how to improve the quality of service delivery, and effective collaboration with family members and conservators.

4. Section 4.1 shall be deleted and replaced as follows:

4.1 Administrative Fee

4.1.1 The CONTRACTOR shall be paid a fixed fee per member per month for specified Eligible Groups for the administration of TennCare Select according to the requirements of this Agreement. The administrative fee to be paid for each specified Eligible Group shall be described in Attachment XVI of this Agreement.

4.1.2 TennCare or its appointed agent shall make payment by the fifth working day of each month to the CONTRACTOR for the CONTRACTOR's satisfactory performance of its duties and responsibilities as set forth in this Agreement. Each month payment to the CONTRACTOR shall be equal to the number of enrollees certified by TENNCARE multiplied by the administrative fee for the appropriate enrollee category. The actual amount owed the CONTRACTOR for each enrollee shall be determined by dividing the appropriate monthly administrative fee by the number of days in the month and then multiplying the quotient of this transaction by the actual number of days the enrollee was enrolled in the plan.

4.1.3 Payment for enrollees shall start the effective date of the enrollee's enrollment in the plan.

4.1.4 The CONTRACTOR agrees the State may retroactively recoup Administrative Fee payments for deceased enrollees. Retroactive recoupment will be deducted from the monthly payment for the following month. Payments may be recouped back to the date of death. This is the only provision whereby the State

may retroactively recoup administrative fee payments from the CONTRACTOR for enrollees retroactively terminated from TennCare Select.

4.1.5 Administrative fee payments made in accordance with Section 4.1.1, 4.1.2, and Attachment XVI will not include payment for children in state custody for whom Immediate Eligibility was established and who were not subsequently found to be TennCare eligible. TennCare shall make a separate payment for said children upon receipt of an invoice from the CONTRACTOR. The invoice shall be submitted to TENNCARE in the form and format specified in Attachment XIII, Exhibit N on a monthly basis. The administrative fee due shall be equal to the number of enrollees for whom Immediate Eligibility was established multiplied by a flat rate equal to the per member per month for Group 1.A, for the full 45 day eligibility period.

4.1.6 As described herein, administrative fee payments made in accordance with Section 4.1.1, 4.1.2, and Attachment XVI will not include payment for enrollees specified in Group 5^{IHSDM}, Persons with Intellectual Disabilities who have been defined as the Target Population for the Integrated Health Services Delivery Model described in Section 3A of this Agreement. For enrollees in Group 5^{IHSDM}, TENNCARE shall reimburse the CONTRACTOR for actual and reasonable cost associated with the management and delivery of covered services to this population based on an invoice submitted by the CONTRACTOR.

4. Section 4.6.1 shall be deleted and replaced as follows:

4.6.1 In no event shall the maximum liability of the State under this Agreement during the original term of the Agreement exceed Four Hundred Million, Five Hundred Six Thousand, Six Hundred Dollars ($400,506,600).

5. Attachment XVI shall be amended by adding a new item V which shall read as follows:

V. Administrative Fee Effective Upon Implementation of the Integrated Health Services Delivery Model

Enrollee Category	Effective Upon Implementation of the Integrated Health Services Delivery Model
Group 1.A	$29.00 PMPM
Group 1.B	$29.00 PMPM
Group 2	$29.00 PMPM
Group 3	$29.00 PMPM
Group 4	$29.00 PMPM
Group 5^{IHSDM}	TennCare shall reimburse actual and reasonable costs associated with the management and delivery of covered services for this population as specified in Section 4.1.6.
Group 5	$29.00 PMPM
Group 6	$29.00 PMPM

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective January 1, 2010.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION
BUREAU OF TENNCARE

BY: _____
M. D. Goetz, Jr.
Commissioner

DATE: _____

VOLUNTEER STATE HEALTH PLAN, INC.

BY: _____
Sonya Nelson
President and Chief Executive Officer

DATE: _____

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: _____
M. D. Goetz, Jr.
Commissioner

DATE: _____

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: _____
Justin P. Wilson
Comptroller

DATE: _____

GENERAL ASSEMBLY OF THE STATE OF TENNESSEE
FISCAL REVIEW COMMITTEE

320 Sixth Avenue, North – 8th Floor
NASHVILLE, TENNESSEE 37243-0057
615-741-2564

MEMORANDUM

TO: The Honorable Dave Goetz, Commissioner
Department of Finance and Administration

BK CC

FROM: Bill Ketron, Chairman, Fiscal Review Committee
Charles Curtiss, Vice-Chairman, Fiscal Review Committee

DATE: June 23, 2009

SUBJECT: **Contract Comments**
(Fiscal Review Committee Meeting 6/22/09)

RFS# 318.66-026
Department: Finance & Administration/Bureau of TennCare
Contractor: Volunteer State Health Plan, Inc. (TennCare Select)
Summary: The vendor is currently responsible for the provision of TennCare-covered services to children in state custody and high risk individuals, and provides a safety net for other TennCare MCOs statewide. The proposed amendment extends the current contract for an additional year, includes behavioral health coverage to begin September 1, 2009, and increases the maximum liability by $383,130,000.
Maximum liability: $982,177,306
Maximum liability w/amendment: $1,365,307,306

After review, the Fiscal Review Committee members present unanimously recommended approval of the contract amendment. The Committee did not formally adopt the recommendation due to absence of a quorum. The recommendation will be presented for ratification at the next Committee meeting.

cc: The Honorable Darin Gordon, Deputy Commissioner
Mr. Robert Barlow, Director, Office of Contracts Review

Leni Chick

From: Leni Chick
Sent: Wednesday, July 08, 2009 12:13 PM
To: 'Dave Goetz'; 'Robert Barlow'; 'Mary.Anne Queen'
Cc: 'Ben Riley'; 'Darla Powell'; 'Eugene Neubert'; 'Glenda Case'; 'Jim Shulman'; 'Lori Yopp'; 'Ricky Frazier'; 'Susan Cooper, Commissioner'; 'Terrie Nelson'; 'Alma Chilton'; 'Betty Boner '; 'Cris McCoy'; 'Darin Gordon'; 'Keith Gaither'; 'Kimberly Hagan'; 'Mary Roberts-Krause'; 'Steve Curry'; 'Andrea White'; 'Laurie Lee'; 'Marlene Alvarez'; 'Mike Morrow'; 'Bruce Opie, Legislative Liason'; 'Kristen McKeever'; 'Randy Carroll'; 'Robert Greene'; 'Tim Webb, Commissioner'; 'Bo Irvin'; 'Emily Wilson'; 'Gary Tullock'; 'Jackie Baker'; 'Priscilla Wainwright'
Subject: Action of the Fiscal Review Committee regarding June 22, 2009 meeting

Commissioner:

This message is to confirm that the Fiscal Review Committee formally adopted the comments of the Committee members present at the June 22, 2009, meeting on all contracts heard at that meeting. The memorandum that you previously received now reflects the official action of the Committee.

If you have any questions or need additional information, please let me know. Thank you, Leni

Leni S. Chick
Contract & Audit Coordinator
Fiscal Review Committee
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